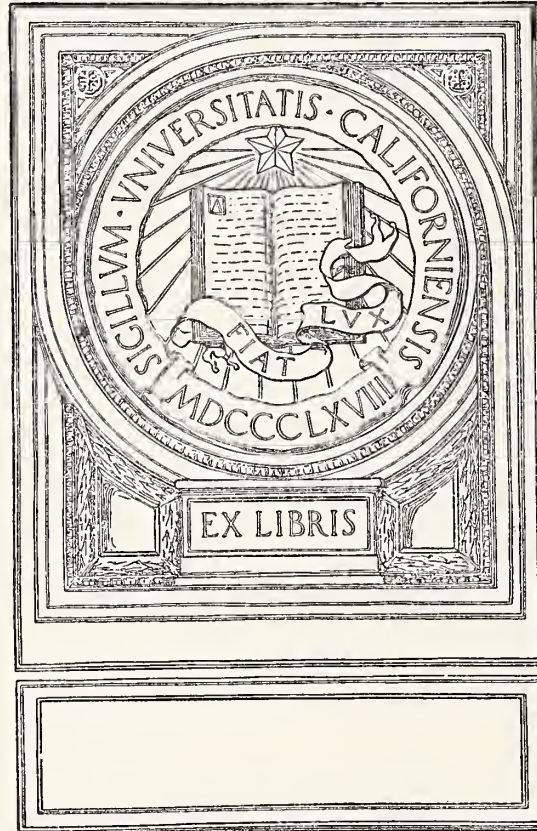
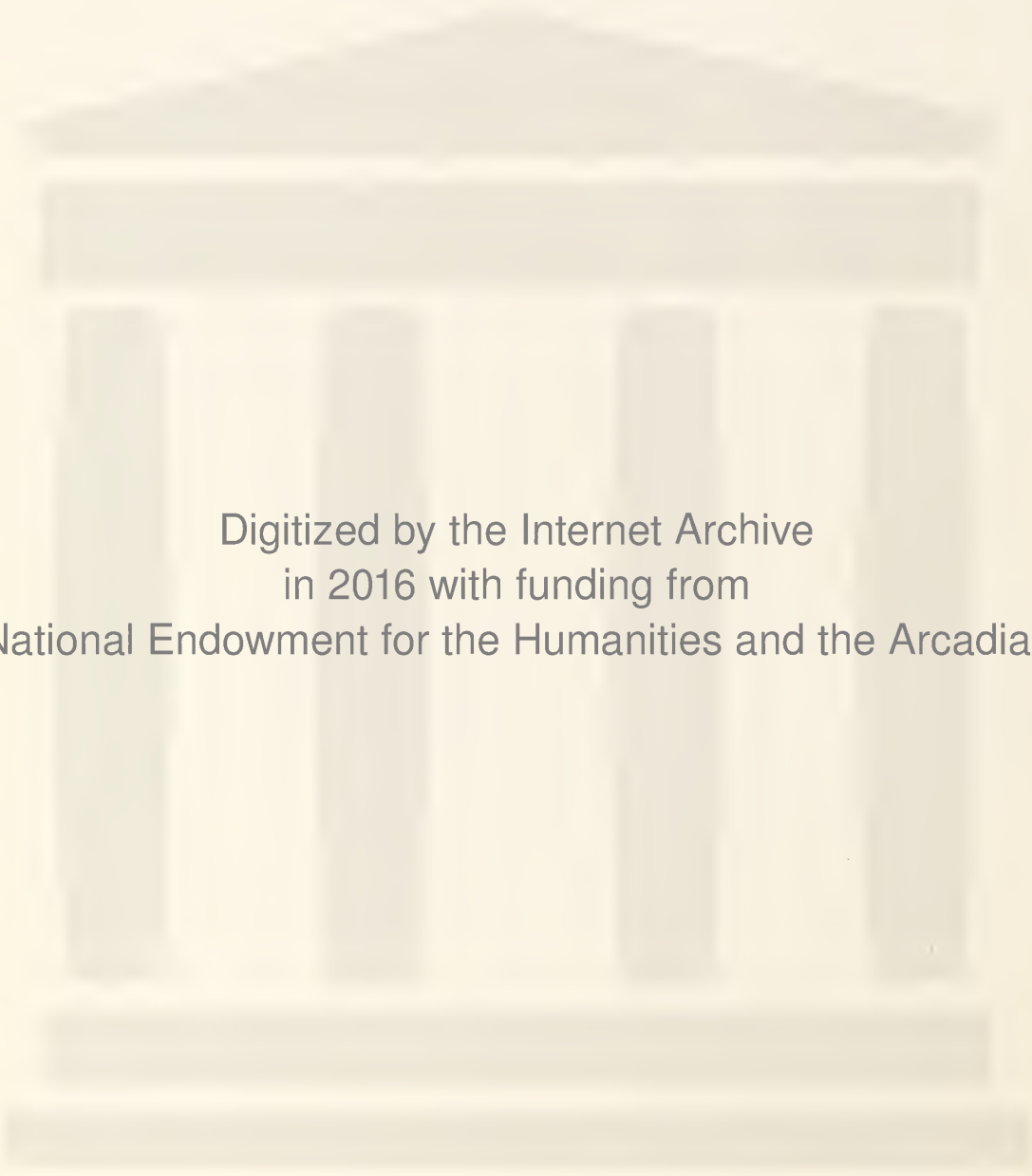


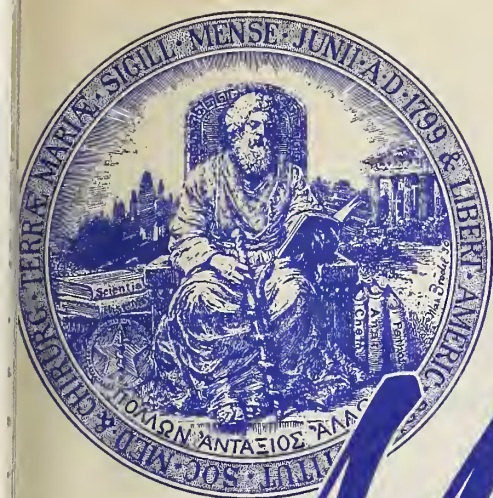
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VOLUME I

January, 1952

NUMBER 1

CONTENTS

Foreword.....	GEORGE H. YEAGER, M.D.	1
Officers' Corner		
The Activities of the Medical and Chirurgical Faculty.....	WALTER D. WISE, M.D.	3
A Message from the Treasurer.....	J. ALBERT CHATARD, M.D.	6
A Statement by the Chairman of the Council.....	C. REID EDWARDS, M.D.	7
Annual Meeting Dates.....		7
Reports		
Maryland Advisory Committee to Selective Service.....	R. WALTER GRAHAM, M.D.	8
Maryland Civil Defense Medical Services.....	R. H. RILEY, M.D. and H. G. FRITZ	10
Building Fund Committee.....	ALBERT E. GOLDSTEIN, M.D.	13
Scientific Papers		
Midcentury Challenge.....	A. AUSTIN PEARRE, M.D.	16
Medicolegal Symposium—Drug Addiction.....		21
Component Medical Societies		
Programs of the Baltimore City Medical Society and Its Sections.....		28
Charles County.....		30
Prince George's County.....		30
Talbot County.....		30
Washington County.....		32
Baltimore City.....		32
Montgomery County.....		32
Library.....		34
Board of Medical Examiners—Article I.....	LEWIS P. GUNDRY, M.D.	38
Health Departments		
State.....	R. H. RILEY, M.D.	39
Baltimore City.....	HUNTINGTON WILLIAMS, M.D.	39
Hospital News		
Hospital and Health Facility Construction under Maryland Hospital Survey and Plan	HERBERT G. FRITZ, Chief	40
Present Status of Study of Prematures.....	PAUL HARPER, M.D.	42
Insurance		
Blue Shield.....		44
The Auxiliaries		
Woman's Auxiliary to the Medical and Chirurgical Faculty.....		45
Ancillary News		
Pharmacy Section.....	L. M. KANTNER, PHAR.D.	47
Letters to the Editor.....		48

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VOLUME I

February, 1952

NUMBER 2

CONTENTS

Officers' Corner, Comments.....	GEORGE H. YEAGER, M.D., Editor and Secretary	49
Reports		
Committee on Scientific Work and Arrangements.....	BEVERLEY C. COMPTON, M.D.	50
Committee for the Study of Certain Phases of Medical Economics.....	WALDO B. MOYERS, M.D.	51
Committee for the Study of Pelvic Cancer.....	BEVERLEY C. COMPTON, M.D.	52
Scientific Papers		
Panel Discussion—Peptic Ulcer.....		53
Harvey B. Stone, M.D.....		53
Sherman M. Mellinkoff, M.D.....		54
John Tilden Howard, M.D.....		56
Jacob E. Finesinger, M.D.....		59
David M. Gould, M.D.....		61
C. Reid Edwards, M.D.....		64
Discussion.....		68
Selected Bibliography.....		74
Drug Addiction Symposium (continued).....		78
Honorable Joseph Sherbow.....		78
James V. Lowry, M.D.....		83
Rozel C. Thomsen, Esq.....		87
Discussion.....		89
The Diagnosis of Chronic Viral Hepatitis.....	VICTOR M. SBOROV, M.D.	92
Component Medical Societies		
Allegany-Garrett County.....		97
Anne Arundel County.....		97
Baltimore City.....		97
Also section programs.....		98
Calvert County.....		101
Caroline County.....		101
Carroll County.....		101
Dorchester County.....		102
Frederick County.....		102
Howard County.....		103
Montgomery County.....		103
Prince George's County.....		103
Queen Anne's County.....		103
St. Mary's County.....		104
Talbot County.....		104
Washington.....		104
Wicomico.....		104
Library.....		105
Civil Defense		
Casualty Clearing Stations.....		107
Allegany Garrett County Medical Society.....		108
The Medical Profession and Civil Defense.....		108
Health Departments		
Baltimore City.....		109
Insurance		
Blue Cross.....		112
Hospital News		
Licensing of Hospitals.....		113
Woman's Auxiliary to the Medical and Chirurgical Faculty.....		116
Ancillary		
Nursing Section.....		118
Pharmacy Section.....		119

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VOLUME I

March, 1952

NUMBER 3

CONTENTS

Annual Meeting	
Scientific Program	121-128
Exhibits	125
Woman's Auxiliary Program	129
Creative Arts Show	130
Business Sessions	
Council	131
House of Delegates	132, 133
Nominations	133
Committees, etc.	134, 140
Officers Component Medical Societies	135
Scientific Papers	
Past—Present—Future	J. ALBERT CHATARD, M.D. 146
Reports	
Committee for the Study of Pelvic Cancer	BEVERLEY C. COMPTON, M.D. 150
Unity by Faith	AMOS R. KOONTZ, M.D. 153
Component Medical Societies	
Anne Arundel County	156
Baltimore City	156
Baltimore County	160
Cecil County	161
Charles County	161
Howard County	161
Kent County	161
St. Mary's County	162
Washington County	162
Worcester County	162
Pediatric Seminar	162
Library	
How the Library Can Serve the Physician	PAULINE DUFFIELD 164
Disposition of Book Collections	165
Current Articles by Faculty Members	165
Board of Medical Examiners	
A Discussion of Some Problems Associated with Licensure	LEWIS P. GUNDRY, M.D. 167
Insurance	
Blue Cross and Blue Shield	168
Woman's Auxiliary to the Medical and Chirurgical Faculty	MRS. LEWIS P. GUNDRY 169
Ancillary News	
Baltimore City Dental Society	A. BERNARD ESKOW, D.D.S. 172
Letters to The Editor	173

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VOLUME 1

April, 1952

NUMBER 4

CONTENTS

Editorials

Reports

- Committee for the Study of Pelvic Cancer..... BEVERLEY C. COMPTON, M.D. 176
No Longer Ivory Towers, Committee on Public Medical Education, Baltimore City Medical Society
NEWLAND E. DAY, M.D. 180

Scientific Papers

- The Physician Against Atomic Attack (Stokes Lecture)..... WILLIAM L. WILSON, M.D. 182
Cortisone (Cortone) in the Treatment of Acute Subdeltoid Bursitis..... MARION FRIEDMAN, M.D. 186
Thirty Years of Phytopharmacology or Applications of Plant Physiology to Medical Problems
DAVID I. MACHT, M.D. 188

Symposium on the Doctor In Court

- Introduction..... WALTER D. WISE, M.D. 190
Expert Testimony from the Viewpoint of Trial Counsel..... ROBERT E. COUGHLAN, JR., ESQ. 191
Expert Testimony from the Viewpoint of Industrial Medicine..... THOMAS CONRAD WOLFF, M.D. 195
Expert Testimony from the Viewpoint of Traumatic Surgery..... GEORGE O. EATON, M.D. 199

Library

- A Few Recent Publications by Faculty Members..... 202

Insurance (Blue Shield)

- President's Report to the Board of Trustees..... HUGH J. JEWETT, M.D. 204

- The Woman's Auxiliary to the Medical and Chirurgical Faculty..... 206

- Maryland Society for Medical Research..... DIETRICH C. SMITH, PH.D. 210

Component Medical Societies.

- Baltimore City Medical Society Sections..... 211

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VOLUME 1

May, 1952

NUMBER 5

CONTENTS

Editorial.....	215
Reports	
Committee on Rural Medicine.....	PAGE C. JETT, M.D. 216
Committee for the Study of Pelvic Cancer	BEVERLEY C. COMPTON, M.D. 216
Committee to Cooperate with the American Medical Education Foundation	NEWLAND E. DAY, M.D. 219
Committee on Industrial Health.....	NATHAN B. HERMAN, M.D. 221
Committee on Public Medical Education, Capital Capsules.....	H. HANFORD HOPKINS, M.D. 221
Scientific Papers	
Panel Discussion—Thyroid.....	EDWARD ROSE, M.D., <i>Moderator</i> 224
Psychiatry.....	WILLIAM T. DIXON, M.D. 225
Surgery.....	WILLIAM F. RIENHOFF, Jr., M.D. 226
Internal Medicine.....	T. NELSON CAREY, M.D. 228
Pathology.....	MORGAN BERTHRONG, M.D. 231
Radioactive Iodine.....	SAMUEL P. ASPER, Jr., M.D. 233
Question and Answer Period.....	234
Lingual Thyroid..ZACK J. WATERS, M.D., KENDRICK McCULLOUGH, M.D., AND	NATHANIEL R. THOMAS, M.D. 241
Thyroid (Books available from the Library).....	248
Component Medical Societies	
Allegany-Garrett County.....	250
Anne Arundel County.....	250
Baltimore County.....	250
Montgomery County.....	251
Prince George's County.....	251
Library	
Recent Additions in the Library.....	252
Health Departments	
Maryland State Department of Health.....	ROBERT H. RILEY, M.D. 253
Baltimore City Health Department.....	HUNTINGTON WILLIAMS, M.D. 256
Insurance	
Blue Cross.....	259
Woman's Auxiliary to the Medical and Chirurgical Faculty.....	260
Ancillary News	
Dental Section.....	264
Nursing Section.....	264

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June, 1952

NUMBER 6

CONTENTS

A Message from the President	ALAN M. CHESNEY, M.D.	267
The Maryland County Medical Care Program—A Progress Report	HERBERT NOTKIN, M.D.	268
Reports		
Committee for the Study of Pelvic Cancer	BEVERLEY C. COMPTON, M.D.	272
The Doctor-Citizen in 1952	WHITMER B. FIROR, M.D.	274
Scientific Papers		
Salt	LOUIS KRAUSE, M.D.	277
The Doctor in Court		
Expert Testimony from the Viewpoint of the Psychiatrist	MANFRED S. GUTTMACHER, M.D.	282
Expert Testimony from the Viewpoint of the Jurist	HONORABLE W. CONWELL SMITH	288
Questions and Answers		291
Abscess of the Lung Due to Endamoeba Histolytica Treated by Surgery and Aureomycin		
MILTON GINSBERG, M.D., AND JOSEPH M. MILLER, M.D.		295
Component Medical Societies		
Allegany-Garrett County	LESLIE E. DAUGHERTY, M.D.	299
Baltimore City Medical Society	SAMUEL McLANAHAN, M.D.	299
Ophthalmological Section	ANGUS L. MACLEAN, M.D.	299
Baltimore County	DONALD L. SOMERVILLE, M.D.	301
Washington County	W. D. CAMPBELL, M.D.	302
Library		
Bookplates	PAULINE DUFFIELD	305
Hints for Medical Writers		306
Insurance		
Maryland Hospital Service, Inc.	ALBION K. PARRIS	308
Woman's Auxiliary to the Medical and Chirurgical Faculty	MRS. GEORGE H. YEAGER	309
Dr. Alfred Ullman—A Tribute	LOUIS J. KOLODNER, M.D.	313
Maryland Academy of General Practice	NATHAN E. NEEDLE, M.D.	314

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VOLUME 1

July, 1952

NUMBER 7

CONTENTS

Scientific Papers

- Problems of Practice W. EDWARD GALLIE, M.D. 315
The Problem of Jaundice in Surgery HOWARD K. GRAY, M.D. 322
Medicine's Number One Problem HOWARD A. RUSK, M.D. 331

Reports

- Committee on Public Medical Education—Support the Blue Shield . . . HOUSTON S. EVERETT, M.D. 339

Component Medical Societies

- Allegany-Garrett County LESLIE E. DAUGHERTY, M.D. 341
Anne Arundel County GEORGE C. BASIL, M.D. 341
Baltimore City Medical Society Radiological Section RICHARD B. HANCHETT, M.D. 342
Baltimore County DONALD L. SOMERVILLE, M.D. 342
Carroll County W. H. FOARD, M.D. 342
Harford County CHARLES P. HAYMAN, M.D. 343
Kent County ROBERT E. ENSOR, M.D. 343

Library

- Osler Funds (Bookplate) 344
Recent Publications by Faculty Members 345

Civil Defense

- Maryland BRIGADIER GENERAL ROBERT P. WILLIAMS 347

Health Departments

- Deputy State Health Officer W. D. CAMPBELL, M.D. 349
Relationship Between Inoculations and Poliomyelitis ROBERT H. RILEY, M.D. 350
Monthly Communicable Disease Report ROBERT H. RILEY, M.D. 352

Blue Cross and Blue Shield

- Blue Cross R. H. DABNEY, *Director* 353

Hospital News

- Trends in Hospital Out-Patient Care MERRELL L. STOUT, M.D., AND MRS. PAULINE NEWELL 354

- Woman's Auxiliary to the Medical and Chirurgical Faculty MRS. GEORGE H. YEAGER 357

Ancillary News

- Baltimore City Dental Society A. BERNARD ESKEW, D.D.S. 362
Maryland Board of Pharmacy L. M. KANTNER, PHAR.D. 362
Nursing Section M. RUTH MOUBRAY, R.N. 363

- Letters to the Editor 365

- Maryland Society of Pathologists HENRY L. WOLLENWEBER, M.D. 365

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VOLUME 1

August, 1952

NUMBER 8

CONTENTS

Editorial—Transactions.....GEORGE H. YEAGER, M.D. 367

TRANSACTIONS (Part I)

Scientific Sessions

Presidential Address

Medical Education and Medical Research Are Part and Parcel of the Medical Profession

ALAN M. CHESNEY, M.D. 369

Business Sessions

Minutes of the House of Delegates..... 378-385

General Meeting, Election Board of Medical Examiners..... 386

Reports (Officers, Committees, etc.)

Secretary.....386, 387

Treasurer.....386, 388-396

Council..... 396

Delegates to American Medical Association..... 399

Board of Medical Examiners..... 401

State Practice Act..... 402

Library Committee..... 402

Committee on Scientific Work and Arrangements..... 405-408

Professional Conduct Committee..... 408

Maryland State Medical Journal..... 408

Maternal and Child Welfare Committee..... 409

Memoir Committee..... 410

Eugene Fauntleroy Cordell Fund Committee..... 411

Legislative Committee..... 411

Committee on Medical Research..... 411

Cancer Committee..... 411

Committee on Public Instruction..... 412

Army Medical Library Committee..... 413

Committee on Industrial Health..... 413

Physiotherapy Committee..... 414

Committee to Advise the State Industrial Accident Commission..... 414

Tuberculosis Committee..... 414

Committee on Medical Service and Public Relations..... 415

Mental Hygiene Committee..... 415

Committee on Rural Medicine..... 415

Committee on The Constitution and By-Laws..... 416

Committee on National Emergency Medical Service..... 417

Blood Bank Advisory Committee..... 419

Medical Care Campaign Committee..... 419

Speakers Bureau of the Medical Care Campaign Committee..... 420

Sesquicentennial Committee (New Building)..... 420

Finance..... 420

Building Plans..... 421

Postgraduate Educational Committee..... 421

Diabetic Detection Committee..... 421

Scientific Speakers Bureau..... 422

Advisory Committee to the Woman's Auxiliary..... 422

Committee to Consider the Relationship Between Hospitals and Specialties and the Manner

of Payment for Professional Services..... 423

Committee for the Study of Pelvic Cancer..... 423

Committee to Study Certain Phases of Medical Economics..... 424

Joint Committee with the Bar Association on Medicolegal Problems..... 424

Committee to Cooperate With American Medical Education Foundation..... 425

Special Current Notices

Selective Service.....R. WALTER GRAHAM, M.D. 426

Semiannual Meeting..... 426

Course in the Basic Sciences as They Apply to the Practice of Medicine..... 427

Cancer Section..... 427

The Semiannual Meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty..... 427

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VOLUME 1

September, 1952

NUMBER 9

CONTENTS

TRANSACTIONS (Part II)

Scientific Sessions

- Too Big A Job For One Year (Trimble Lecture) PAUL B. MAGNUSON, M.D. 430
- You and Your A. M. A.*
- You Are the A. M. A. WALTER B. MARTIN, M.D. 436
- The Structure and Functions of the American Medical Association . . . ERNEST B. HOWARD, M.D. 439
- Remarks GEORGE H. YEAGER, M.D. 443
- Questions and Answers 444

Scientific Papers

- The Lower Midline Incision CHARLES B. MAREK, M.D. AND JOSEPH R. DOLCE, M.D. 447

Reports

- Committee On Rural Medicine PAGE C. JETT, M.D. 453
- Socialism Is On The Move ROBERT W. GARIS, M.D. 453
- Mice or Men in November? AMOS R. KOONTZ, M.D. 456

Component Medical Societies

- Allegany-Garrett County LESLIE E. DAUGHERTY, M.D. 458
- Baltimore City, Pathological Section WILLIAM V. LOVITT, JR., M.D. 459
- Baltimore County DONALD L. SOMERVILLE, M.D. 460
- St. Mary's County J. ROY GUYTHER, M.D. 460

Library

- The Charles Frick Reading Room and The William F. Frick Endowment Fund 462
- Civil Defense Bibliography 463

Health Departments

- State Health Department—Some Observations of the British System of Caring for the Aged and Chronically Ill ROBERT H. RILEY, M.D. 465
- Alcoholism, A Medical and Social Problem PAUL V. LEMKAU, M.D. 467
- Monthly Communicable Disease Report ROBERT H. RILEY, M.D. 474

Blue Cross and Blue Shield

- Blue Shield HUGH J. JEWETT, M.D. 475

- Woman's Auxiliary MRS. GEORGE H. YEAGER 476

Ancillary News

- Baltimore City Dental Society A. BERNARD ESKOW, D.D.S. 479
- Nursing Section M. RUTH MOUBRAY, R.N. 479

- Announcement—Julius Friedenwald Memorial Lecture 481

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VOLUME 1

November, 1952

NUMBER 11

CONTENTS

Editorial

Status of Chloramphenicol Therapy.....THEODORE E. WOODWARD, M.D. 537

Special Current Notices

Statewide Study of Premature Infants—The Gesell Developmental Examinations
PAUL HARPER, M.D. 539

Scientific Papers

Symposium on the Use and Misuse of Blood Transfusion in Surgery
Pooled Plasma and Homologous Serum jaundice.....J. GARROTT ALLEN, M.D. 540
Untoward Reactions from Blood Transfusions.....C. LOCKARD CONLEY, M.D. 547
Discussion.....552
Large Hemorrhages from the Bowel of Obscure Origin.....HARVEY B. STONE, M.D. 555

Articles of Interest

Mutiny For a Bounty.....EDWARD F. LEWISON, M.D. 559
The Case of the United States versus the Hoxsey Cancer Clinic.....C. W. CRAWFORD 560

Component Medical Societies

Allegany-Garrett County.....LESLIE E. DAUGHERTY, M.D. 561
Baltimore County.....CHARLES H. WILLIAMS, M.D., AND GEORGE C. MEDAIRD, M.D. 562
St. Mary's County.....J. ROY GUYTHER, M.D. 564
Carroll County.....WILBUR H. FOARD, M.D. 565
Baltimore City.....566

Library

The McCleary Fund.....567
The Stokes Memorial Fund.....567
Recent Publications by Faculty Members.....568

Health Departments

Conservation of Hearing in the Counties.....EDWARD DAVENS, M.D. 570
Monthly Communicable Disease Report.....574

Blue Cross and Blue Shield.....REGINALD H. DABNEY 575

Woman's Auxiliary to the Medical and Chirurgical Faculty.....MRS. GEORGE H. YEAGER 576

THE MARYLAND STATE MEDICAL JOURNAL

Editorial and Business Office, 1211 Cathedral Street, Baltimore 1, Maryland

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Official Publication of the Medical and Chirurgical Faculty of the State of Maryland

VOLUME 1

December, 1952

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CONTENTS

Editorial

- A Message From The President.....ALAN M. CHESNEY, M.D. 579

- Presentation of the Portrait of J. Hall Mason Knox, Jr., M.D.....D. C. WHARTON SMITH, M.D. 580

Scientific Papers

- Geriatrics in General Practice.....WINGATE M. JOHNSON, M.D. 582

- Cholecystography Using Telepaque

- HENRY F. ZANGARA, M.D.; CHARLES N. DAVIDSON, M.D.; WALTER L. KILBY, M.D. 593

Health Departments

- Baltimore City Health Department.....HUNTINGTON WILLIAMS, M.D. 597

- State Department of Health.....ROBERT H. RILEY, M.D. 598

Component Medical Societies

- Allegany-Garrett County.....LESLIE E. DAUGHERTY, M.D. 599

- Section Meetings of Baltimore City Medical Society.....600

- Baltimore County.....DONALD L. SOMERVILLE, M.D. 601

- Prince George's County.....SAMUEL J. N. SUGAR, M.D. 601

- Washington County.....W. D. CAMPBELL, M.D. 601

Library

- Our New Librarian—Miss Helen Wheeler.....602

- The Barker Fund.....602

- The Herbert Harlan Memorial Fund.....603

Blue Cross and Blue Shield

- Why More than 1,600 Maryland Physicians Support Blue Shield.....R. H. DABNEY 605

- Woman's Auxiliary to the Medical and Chirurgical Faculty.....MRS. GEORGE H. YEAGER 606

Ancillary News

- Nursing Section.....611

- Pharmacy Section.....612

- Membership Roster of the Medical and Chirurgical Faculty, March 1951–March 1952.....613

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Maryland STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 1

January, 1952

NUMBER 1

FOREWORD

GEORGE H. YEAGER, M.D.

Secretary and Editor

The advent of this publication represents the culmination of the hopes and efforts of the officer body of the Faculty. At the same time, it marks the demise of the Bulletin and the incorporation of the News Letter.

Scientific articles will be published in as concise a style as possible. Should greater length and detail be desired, access should be made to reprints and the original manuscript.

Circulation figures do not of necessity indicate reader interest. If our State Journal is read throughout, a worthwhile service will have been rendered. The argument has been advanced that it will be difficult to obtain articles for a journal of this size. It is our belief that articles published in a journal for State distribution represents more effective reader interest than journals of larger circulation.

We are fully persuaded that the best interests of the Faculty demand some means of binding individual members more closely to the organization. It is imperative that the work of the State Society, as well as that of the American Medical Association, be kept before the members.

The facilities of the excellent library of the Faculty, to a very large percentage of our membership, are not available because of geographical factors. Other inducements, as well as some direct means of communication, should be offered. Experience has taught other States that the strongest influence for good in these directions has been a State medical journal, owned and controlled by the State Society, managed solely in the interest of its members, and sent to each of them regularly without cost beyond their annual dues.

Issuance of a journal at this time represents re-vitalization of an old custom of the Medical and Chirurgical Faculty. The venture is neither a "new idea," nor a "new departure."

From October 1839 to June 1843 the Faculty published the "Maryland Medical and Surgical Journal and Official Organ of the Medical Department of the Army and Navy of the United States." From May 1887 to March 1918 a publication known as the "Maryland Medical Journal" (Vol. 1, 61, #3) carried the notes and communications of the Faculty. For a brief period (1905-1908) this Journal became the official publication medium of the Faculty and included the transactions. In 1908 The House of Delegates of the Faculty terminated its contract with the Maryland Medical Journal for publication of the transactions and initiated an official monthly Bulletin, which was discontinued in 1922. This contained scientific articles,

transactions and local items of interest, and was quite different from the small 4 to 8 page Bulletin, which has been published since 1927 to date.

Many objections have been raised to the re-establishment of a Journal. Certainly it represents an increased burden for the office staff. If you want a Journal, issued by your State Society, lend your support. Read it! Criticize it! Help make it worthwhile! If you are willing to include it as essential reading to your professional way of life, then it must succeed.

Add it to your hedonistic as well as your professional pursuits. The probability of the *Maryland State Medical Journal* becoming a fixed asset of the Medical and Chirurgical Faculty of Maryland will thereby be enhanced.

A SUGGESTION FROM THE EDITOR

The Editor requests that the members of the Medical and Chirurgical Faculty submit for publication items of interest to the profession, case reports and scientific papers. It's your JOURNAL; make it a success by contributing.

Officers' Corner

THE ACTIVITIES OF THE MEDICAL AND CHIRURGICAL FACULTY

WALTER D. WISE, M.D.

President, 1951

For a long time, it has been evident to officers of the Medical and Chirurgical Faculty that many members have inadequate knowledge of the activities of this Society and its indirect value to them. Some members feel that because they do not use the Library, for reasons of distance, lack of time or some other cause, they get no benefits beyond the pleasure and advantages of the medical meetings, which in most state societies are limited in number, (this function being for the most part the responsibility of the city and county components). Because it seems necessary that the manifold activities of our State Society and its components become better known, it was decided to find a more fitting medium for the transmission of their transactions. To this end, as is pointed out elsewhere in this issue by Dr. Edwards, Chairman of the Council, it was decided to publish a JOURNAL. It is almost certain that at no time in our history has it been more important to have a well organized and supported state medical organization.

The number of doctors in our Society has increased from 1232 in 1925 to 2401 in December 1951, and the activities of our organization have multiplied to a very great degree.

In 1925 there were the same three committees, as we have today, which are elected by the House of Delegates: The Committee on Scientific Work and Arrangements, the Library Committee and the Finney Fund Committee. The Professional Conduct Committee, which was inaugurated in April 1950, is the only other committee included in the Constitution and By-Laws.

The work that may be called routine, such as that of the Library, which has about doubled in the past 25 years, the regular medical meetings, the Council

meetings and those of the Standing Committees, has gone on as before except for a considerable increase in the volume of work and the results. At present there are 32 appointed committees, of which 6 were in existence in 1925, at which time there were only 8 committees all told.

In addition to the duties of the regular standing committees, some of the newer matters that have called for varying numbers of meetings and hours of work and which have resulted, in some cases, in the appointment of additional Standing Committees, are:

- a. Our part in developing the Blue Cross, on whose Board (Maryland Hospital Service) we have 24 corporate members.
- b. Our part in the development of the Blue Shield, on whose Board (Maryland Medical Service) we have 8 Class "A" members.
- c. The development of the Medical Care Plan. (As a result of a recommendation of the House of Delegates of the Medical and Chirurgical Faculty.)
- d. A detailed survey of the Hospitals of Maryland under direction of the Medical Committee of the State Planning Commission.
- e. Aid in the implementation of the Hill-Burton Act, of which funds there has been spent in Maryland in the past four years \$4,177,000 of Federal money. By June 1952 the amount will be \$5,197,836.06. There has been participation in twenty-five projects, with a total expenditure at the end of the current year of over \$17,000,000. This has been done through a state-wide committee of laymen and representatives of the State Department of Health and the Medical and Chirurgical Faculty.

- f. The Faculty has representatives on the Red Cross Regional Blood Center Blood Program Committee and Medical Committee.

The representatives of the Faculty on the above mentioned Boards, Committees, etc. conduct their activities independent of the Faculty office. The Chairmen of the 32 existing Committees carry on the functions of their Committees usually through the office of the Faculty.

The Committees which functioned in 1925 and are still in existence are as follows:

1. Maternal and Child Welfare Committee, which has been very active and helpful in reducing the mortality rate in newborn babies and young children.
2. Memoir Committee.
3. Eugene Fauntleroy Cordell Fund Committee. (Formerly Fund for Widows and Orphans, and given present name to honor Dr. Cordell.)
4. Committee on Public Instruction. Radio and television programs are given under the auspices of the Medical and Chirurgical Faculty and Baltimore City Health Department, and other public educational programs through State and City Health Departments.
5. Committee on Defense of Medical Research. A most recent activity was the fine work in the Antivivisection fight in Baltimore City, and resulted in the formation of the Maryland Society for Medical Research—a strong organization deserving of warm support.
6. Legislative Committee. There has always been a Legislative Committee and the work carried on by these members, particularly during the time when the General Assembly meets in Annapolis which is now every year, is a very heavy load. Members of this Committee, particularly the Chairman, are compelled to spend much time at Annapolis to attend meetings of the Legislature so as to bring to the attention of the members of the House and Senate the effect on the public of Bills pertaining to medicine and related matters. The Committee makes every effort to protect the health and welfare of the citizens of Maryland.

Since 1925 the following Committees, besides others which have been discharged, have been appointed and in most instances the name indicates the work of the Committee:

1. Committee on Constitution and By-Laws. The

Faculty now has a standing Committee on Constitution and By-Laws and in these changing times this Committee spends a great deal of effort in keeping the Constitution current.

2. Physiotherapy Committee.
3. Army Medical Library Committee.
4. Cancer Committee.
5. Tuberculosis Committee.
6. Mental Hygiene Committee.
7. Committee on Rural Medicine. This Committee has held in recent years two Rural Health Conferences in the Faculty Building, which were attended by physicians and lay people from throughout the State.
8. Committee on Industrial Health.
9. Blood Bank Advisory Committee.
10. Medical Care Campaign Committee. The Council at its meeting on February 10, 1949 adopted the recommendation of a Special Committee and authorized the formation of this Committee, which has representatives from every County in the State, as well as a Speakers Bureau. This Committee disseminates educational information to the public, provides speakers, and carries on an active campaign against Federalized medicine.
11. Sesquicentennial Committee (New Building).
Subcommittees:
 Finance.
 Building Plans.
12. Committee to Advise the State Industrial Accident Commission.
13. Committee on Medical Service and Public Relations.
14. Postgraduate Educational Committee.
15. Diabetic Detection Committee.
16. Committee to Study Certain Phases of Medical Economics.
17. Committee to Consider the Relationship Between Hospitals and Specialties and the Manner of Payment for Professional Services.
18. Presidential Advisory Committee.
19. Civilian Defense Committee with its several subcommittees.

Some of the recently appointed Committees are functioning as follows:

20. A Scientific Speakers Bureau has made available to the Component Medical Societies a list of physicians, who will address their societies on current medical subjects.

21. Advisory Committee to the Woman's Auxiliary, which consists of five Faculty members who are available at all times to assist and advise the officers of the Auxiliary in their projects.
22. The Advisory Committee to the State Health Department, which meets with members of the State Health Department to iron out any difficulties which may arise between the profession and State Department of Health. This is an active Committee and an able detailed report was given by Dr. A. A. Pearre at the Ocean City Semiannual Meeting, September 14, 1951.
23. Professional Conduct Committee. Never a week goes by that this Committee does not receive mail from either lay people or doctors embodying complaints. This Committee gives a great deal of study to the problem and settles the differences in many cases.
24. The Committee for the Study of Pelvic Cancer was approved by the House of Delegates and Council in April 1951 and has set up an office in the Faculty building under the auspices of the American Cancer Society.
25. In recent months a Joint Committee of the Faculty and Bar Association has been formed and it is hoped through their efforts to have a closer liaison between the Medical and Legal professions. To this end they are holding symposiums on timely subjects to which the medical and legal professions, as well as the public, are invited. One important meeting on the Narcotic Problem has been held. In December there will be a meeting on Court Procedures.

The amount of time and thought put into the efforts of these committees and the amount of material reported out, would surprise anyone not familiar with the proceedings. Perhaps the unknowing visualize the Committees as having a meeting or two and finishing their work. This is true in a few instances. Those who were responsible for developing the Blue Shield, the Medical Care Plan for the Indigent, those who worked on the "dog fight" or made the hospital survey for the obtaining of the Hill-Burton Act funds, would have a different account to relate.

The amount of material that comes to 1211 Cathedral Street from the Chicago and Washington offices

of the American Medical Association, and almost countless independent groups of doctors and lay organizations, largely concerning matters detrimental to the profession or public welfare would likewise be surprising. This has to be read and acted upon. As stated, the Maryland Legislature now meets yearly instead of every two years as formerly and this means that the Legislative Committee and Director of the Faculty have to give almost twice as much time as formerly to the guarding of the public interest.

Probably few of our members know that under the Law the Governor of Maryland requests the officials of the Medical and Chirurgical Faculty to submit lists of names, from which he makes appointments on the following Boards:

1. Medical Board for Occupational Disease for the State Industrial Accident Commission.
2. Council on Medical Care of State Department of Health.
3. Advisory Council on Hospital Construction to the State Board of Health.
4. Advisory Board to the State Department of Health for Licensing of Hospitals.
5. State School Health Council.
6. State Board of Physical Therapy Examiners.

The first Annual Meeting of the Woman's Auxiliary of the Medical and Chirurgical Faculty was held in April 1950 and this organization is taking an active part in community affairs, educational projects, etc., and the Faculty office is doing the secretarial and clerical work of the Auxiliary.

One outstanding function of our State Society that should be cherished and forever protected is the election of the State Board of Medical Examiners. As far as we know, we are the only State having this privilege.

These are some of the many activities to which the members of the Medical and Chirurgical Faculty give their time, advice and knowledge to help the citizens of the State of Maryland. Many of you are on some of these committees, some have wide knowledge of the activities of the Society as a whole—many do not. To acquaint the entire membership with our state-wide activities is one of the chief reasons for the desire to publish a larger Journal.

For the most part, the subjects just mentioned are at the state level. About one-half of the State Society membership is in Baltimore City. The Baltimore City Medical Society uses the Faculty head-

quarters and office staff. Their Society is broken up into numerous sections, with their many meetings which have to be arranged. They have their own committees as follows:

1. Committee on Geriatrics.
2. Committee on Emergency Medical Calls.
3. Health and Physical Education.
4. Hospital Survey Committee.
5. Legislative Committee.
6. Maternal Mortality Committee.
7. Maryland Committee Against Un-American Activities.
8. Program Committee.
9. Committee on Public Medical Education.
10. Magistrate's Committee.
11. Membership Committee.

The City Society also has its own Woman's Auxiliary. The activities of the Baltimore City Medical Society plus those of the County Societies, of course, are to be added to the total accomplishment of the State Society.

The Bulletin of the Medical and Chirurgical Faculty, a leaflet, was inaugurated in December 1927 to

give the members a concise account of the activities of the State Association. Subsequently, in April, 1949, the Secretary, Dr. Yeager, felt that it would be advisable to supplement the Bulletin with a News Letter, which would be informal and carry information to the members relative to the activities of the Medical and Chirurgical Faculty, American Medical Association, etc. The Journal will bring the information contained in the Bulletin and News Letter, plus scientific articles and editorials. We hope it will be extremely valuable.

One sometimes hears the inquiry—what do I get out of the State Society for my dues? We hope the reading of this Journal will give a clear answer. One answer that has been true over the years is—you have working for your interest and in the interest of the public, several hundred committeemen who give a surprising amount of time and energy. Their services could not be purchased with money.

It is hoped that in forthcoming issues of the Journal, the members will become familiar with the activities and accomplishments of the Medical and Chirurgical Faculty.

A MESSAGE FROM THE TREASURER

J. ALBERT CHATARD, M.D.

Another milestone has been reached by the Faculty. Last year as your Treasurer I advised an increase of dues. Such a recommendation had become necessary because of the continued rising cost of upkeep. With the recommendation there was included the hope that a Journal would be published, and that it would serve as a medium of cementing our relations throughout the State. This hope now sees its fruition with the issuance of *The Maryland State Medical Journal*, as the official publication of the Medical and Chirurgical Faculty.

I know the Editorial Board intends to utilize the Journal as a means of reaching our membership with news, reports, and programs of our Component Societies, as well as timely and interesting addresses and scientific papers.

It is planned to print the Transactions in the Journal. The presidential address, reports of the

committees and House of Delegates, and the scientific papers, as presented during the Annual Meeting, will be published as soon as feasible after the April 1952 meeting.

Please don't look on this as another medical journal in an already crowded field. Think of it as your home paper, with news you want to hear. Your Officers have neither time nor means to talk to each member in person. The work of the office cannot be appreciated or known except through the medium of a Journal.

If it proves to be a worthy publication, please give it your heartfelt support and praise. Criticism is requested, and suggestions for improvement eagerly sought.

Ultimate good can be accomplished if each member will take pride in his Association, THE FACULTY, and support its efforts.

A STATEMENT BY THE CHAIRMAN OF THE COUNCIL

C. REID EDWARDS, M.D.

With the issuance of *The Maryland State Medical Journal*, the Medical and Chirurgical Faculty moves forward. Thereby it hopes to transform the Bulletin which has served a good, though inadequate, purpose into a Journal which will lend itself to a planned expansion and serve the medical profession of the State of Maryland in a way that has not been possible in the past.

The importance of a thoroughly organized, alert State Society has never been so evident as at present. It is imperative that every physician in the State be acquainted with the duties, responsibilities and potentialities of the Medical and Chirurgical Faculty. The Journal should serve as a medium of conveying necessary information to everyone. While the de-

tails of administrative duties must be attended by its elected officers and numerous appointed committees, every member of the Faculty should know what is required of the Faculty and what is being done. It now will be possible to keep every one informed and thereby to consolidate the efforts of the Faculty and to make it the living, forceful organization it should be.

Temporarily the responsibility of editing this Journal is the duty of the Secretary. A committee is working on a permanent plan for its editing. The result should be a publication equal, if not superior to other State Medical Journals.

Your coöperation in the support of this Journal is solicited.

ANNUAL MEETING DATES

Tuesday and Wednesday, April 29 and 30, 1952

Due to a conflict of dates with National Associations, the Council of the Medical and Chirurgical Faculty has authorized the Chairman of the Committee on Scientific Work and Arrangements, Dr. Beverley C. Compton, to change the date of the Annual Meeting to Tuesday and Wednesday, April 29 and 30, 1952. The House of Delegates will meet on Monday, April 28, 1952. To date Dr. Cornelius P. Rhoads of New York has been obtained as one of the principal speakers. He will address the meeting on Tuesday evening, April 29, 1952 on "Recent Developments in Cancer Research."

Reports

THE MARYLAND ADVISORY COMMITTEE TO SELECTIVE SERVICE—A REPORT

DR. R. WALTER GRAHAM, JR.

Chairman

On October 7, 1950, the Maryland Advisory Committee on the Selection of Physicians, Dentists, and Allied Specialists was appointed by Dr. Howard Rusk, Chairman of the National Advisory Committee. Dr. Rusk's authority for such action was established by Public Law 779 and by order of the President of the United States. Those named by Dr. Rusk were: R. Walter Graham, Jr., M.D., Chairman, Robert H. Riley, M.D., and Harry B. McCarthy, D.D.S. The order of appointment stated that "the Chairman may appoint such additional members to the Committee as may be necessary to carry out its functions. Your Committee shall appoint such volunteer advisory subcommittees to serve at local levels as may be necessary; e.g., separate committees of doctors, dentists and veterinarians to give appropriate consideration to the respective needs of the armed forces and of the civilian population for the services of the members of their respective professions." The order of appointment further stated that "the responsibilities of your committee are (1) to establish and maintain liaison with your State Director of Selective Service, (2) to advise the Selective Service System concerning the classification of individual members of these health professions who are subject to classification by the Selective Service Boards, (3) to be responsible for carrying out within the State policies established by the National Advisory Committee."

To the original members of the Committee, the following have been added: Whitmer B. Firor, M.D., Arthur L. Brueckner, D.V.S., Mrs. Angela Shipley, R.N., and John W. Parsons, M.D. Regional members to advise with the county draft boards are as follows:

Physicians

O. H. Binkley
Jacob W. Bird
H. A. Cantwell
Arthur H. Hawkins
Byrd Hopkins
James T. Marsh

Waldo B. Moyers
William D. Noble
A. Austin Pearre
Edward P. Thomas
Robert S. G. Welsh
Peregrine Wroth

Dentists

Thomas Bland
Crown O. Diehl
Stanley Mathews

James Russell Cook
Mayo B. Mott
Harold Conner

Veterinarians

H. L. Baker
F. S. Wharton
J. Walter Hastings, Sr.

Charles S. Koble
Fletcher Vinson

These gentlemen were authorized to augment their number wherever necessary to carry out the program as expeditiously as possible. It must be borne in mind that the first registration was to come only nine days after the appointment of the nucleus of the Advisory Committee. Haste was necessary. No one knew at the time to what extent this country might become involved in armed conflict. The Korean crisis had brought sharply into focus the serious lack of professionally trained personnel in the armed forces. Certain criticism has been voiced by county medical societies and local hospital groups that committees which had been organized under an earlier system by them were by-passed at this time. Our only reply can be that a new system had been created practically overnight at a national level. The emergency of the situation demanded haste and expeditious action. It could have been that we might have found ourselves with more committee members than special registrants to be processed. We can state with

just pride that Maryland was among the first, if not the first State, to have completed the processing of all professional men who registered on October 16, 1950.

We wish to take this occasion to thank all members of this group who have contributed their services voluntarily to this program. Some members have come long distances in inclement weather to attend hastily summoned conferences. It might be of interest to note here that the sum of \$5,000 was allotted to this Committee for expenses for the period January 1, 1951, to June 30, 1951, and \$1,000 for the year July 1, 1951, to June 30, 1952. Such is the lavish hand of government today. Actually the Committee has requested reimbursement for less than \$50 up to the present time!

It would be a serious omission not to comment upon the splendid cooperation that has been shown this Committee by the Director of Selective Service, Col. Henry C. Stanwood, and the sixty-six draft boards in this State. The draft boards have concurred with the recommendations of the Advisory Committee in almost every case. By and large the same cooperation has been shown by the draft boards of other states with few exceptions. It must be emphasized, however, that the sole function of the Advisory Committee is to pass an opinion to the draft board concerned upon the professional availability or non-availability of a special registrant for military service. Physical disability, dependency, and financial hardship, when claimed, are ruled upon solely by the draft boards.

It is to be regretted that we cannot give accurate figures on the number of men processed under the first registration of October 16, 1950. This is so for various reasons. First of all, the draft boards do not report to us their decisions except in cases of appeal. To do so would add greatly to the heavy burden of their secretarial staffs, for whom the "doctor draft" is only a small part of their work. There are a number of doctors in training who are not residents of Maryland, but who registered at the time with Maryland boards. Conversely, there are a number of legal residents of this State temporarily residing out of the State, who have registered with out-of-state boards.

Up to the present there has been no attempt made to process professional men in Priority III (no military service since September 16, 1940) and those in

Priority IV (veterans of World War II) with this exception. We have been requested by the National Advisory Committee to express an opinion upon the present status of members of the Reserve Corps of certain branches of the Service. This does not mean that those men contacted can look forward to recall into the Service within the foreseeable future, except for those reservists who were in Priority I and II under the Draft Act. It is planned to have an up-to-date appraisal of the professional status of each officer in the Reserve Corps in a file of the State Advisory Committee. The military forces have agreed that no reserve officer will be called to duty without consultation with the Advisory Committee.

In a recent article in the Journal of the American Medical Association, Dr. Howard Rusk has very aptly summed up the policy: "It is particularly significant, I think, that by mutual agreement the military services for the first time in history have permitted a civilian group to be placed between them and their reserves, and in the interest of total national welfare rely upon its advice and recommendations in calling their reserves to active duty." To comply with this agreement, it will be necessary from time to time to contact members of the Reserve Corps for pertinent information. It is requested that such men give our questionnaires their prompt attention. Otherwise the whole program can fall to pieces. This must not be allowed to happen.

In conclusion, we should like to comment upon the splendid coöperation that has been extended to us by the Surgeon of the Second Army, Fort George Meade, and the Offices of the Surgeon General of the Army, Navy and Air Force. We are pleased to report that not once has a request of ours for even a last minute deferment of an officer been refused, and in several cases it has required a great deal of prompt action to fulfil such request. It would be inappropriate to close without commenting upon the excellent coöperation shown by the superintendents of hospitals, the heads of departments of medical schools, and the chiefs of hospital staffs who have worked so closely with us. Finally, a word should be said about the Special Registrants themselves. We have had personal contact with a great many of them. We have been tremendously impressed by their willingness to sever their civilian

careers and enter the military services in this emergency. Most requests for deferment have been for a comparatively short period of time in order to complete a hospital year or to close a practice. The great majority who have been found eligible have already signified their intention to accept a com-

mission in the armed forces, and a goodly number are already on active duty. No professional men from this State have been drafted into the Services as an enlisted man to our knowledge up to the present time. This is a record of which we can all be justly proud.

MARYLAND CIVIL DEFENSE MEDICAL SERVICES

DR. R. H. RILEY

Director, Medical Services Division

AND

H. G. FRITZ

Acting Deputy Director, Medical Services Division

The present status of the Medical Services aspects of Civil Defense is encouraging but not reassuring.

During the twelve months since responsibility for this phase of Civil Defense was placed with the State Department of Health on recommendation of the Medical and Chirurgical Faculty, specific policies and detailed plans have been developed in special fields by the appointed chiefs and their advisory committees. As policies and plans have been developed, they have been sent as Bulletins to Local Directors of Medical Services for execution. Twenty such bulletins have been issued.

The response of appointees to the State organization as chiefs and members of advisory committees and their diligence in meeting their assignments has been encouraging. However, their responsibility at the State level is limited to policy making and planning. Written policies and plans give no assurance of ability to meet an emergency such as can be expected following enemy action.

Local civil defense areas are autonomous and, therefore, responsible for the implementation and execution of recommended plans. Some encouragement can be derived from the reported progress of planning and organization in local defense areas. However, progress is not uniform. Where specific appointments have been made, they are limited to

key personnel. No complete operational medical units have as yet been established.

There can be no assurance of readiness to meet an emergency until adequate personnel are trained and organized into operational units; until buildings have been committed; and until supplies and equipment are available.

The problem, therefore, is made up of three major factors which are:

1. People—recruited, trained and organized
2. Buildings—committed and specific plans made for their utilization
3. Supplies

PEOPLE

The most important resource is people. They fall into two groups. The first group is composed of professional people regularly engaged in medical fields. The second group, much larger and more flexible, is made up of non-professional people who must be given special training not only to survive but also to be capable of rendering service as members of operational units.

Questionnaires for physicians, dentists, nurses, pharmacists and morticians were prepared at the State level and distributed by Local Directors of Medical Services. Completed replies are being returned, in duplicate. Original copies are retained at

the local level for use in making assignments. Copies are sent to the State office to become a part of the master file.

Questionnaires were distributed and registration is being made on the basis of place of residence. However, assignments will be made following collaboration by the Local Directors of Medical Services of contiguous areas on the basis of choice of the registrant consistent with the most effective use of the candidate's training and ability.

Non-professional personnel is required in large numbers for Medical Services as well as for the other divisions of the Civil Defense organization, such as police, fire and welfare. The Red Cross offers training courses for such personnel in Home Nursing, First Aid, Canteen and Nurses Aide work. These trainees will be largely absorbed by the Medical and Welfare Services. In addition to these four groups of volunteers, there is need for volunteer auxiliary workers such as laboratory and x-ray technicians, administrative and maintenance personnel, and others.

Enrollment for a Red Cross training course is not a commitment for service in Civil Defense. The local Civil Defense organization assumes the responsibility of obtaining a commitment from trainees to accept assignments in the Civil Defense organization.

Professional and voluntary personnel are needed in large numbers in two of the four subdivisions of Medical Services. The subdivision for Medical Care needs volunteers in first aid to staff First Aid Stations and Casualty Clearing Stations. Other volunteers will be needed for the expanded hospitals. Planning for hospital services places upon existing hospitals the responsibility to expand to eight times normal capacity. It is quite obvious, therefore, that large numbers of both professional and non-professional volunteers will be required to service this tremendous expansion of hospital beds. Additional numbers of volunteers will also be required to render essential community services. This unit of Medical Services will be responsible for the non-casualty patients, that is, the usual home and office patients, of whom it can be anticipated there will be many.

The second subdivision which will require trained volunteers encompasses public health services. The sub units of this field of service include food and

sanitation, industrial health, vital statistics and mortuary services, laboratory services and veterinary services. Volunteers will be needed for clinical and public health laboratory services and mortuary services.

The remaining two subdivisions are Special Weapons Defense and Supplies. Special Weapons Defense, which is defense against biological and chemical warfare, will be carried on largely by the existing Public Health Services. The public health laboratories will play a vital role. The subdivision responsible for Supplies will not require many volunteers beyond the planning and allocation, since supplies will be issued by the State Director of Civil Defense to the Local Directors.

Tables of organization for first aid stations, casualty clearing stations and hospitals have been prepared and published in Medical Bulletins or supplements to the Maryland Plan. Organization for a first aid station is made up of three first aid teams, each team having one leader and eight litter bearers, all of whom have been trained in first aid. In metropolitan areas, first aid stations should be organized on the ratio of one station for each four city blocks. The minimum number of first aid stations should be a ratio of five and preferably ten per casualty clearing station. First Aid Stations have been defined in the State plan as "... those points established as close as possible to the periphery of the damaged area to which litter bearers will carry casualties for transfer to vehicular transportation and to which walking casualties will be directed for First Aid. These First Aid Stations will function as advance posts and satellites of Casualty Clearing Stations. They will be staffed by first aid workers only. No physicians will be assigned to First Aid Stations."

Casualty Clearing Stations, according to the State plan, should be set up on a minimum ratio of one for each 10,000 population in populous areas. The table of organization for a casualty clearing station calls for 53 persons, including 2 physicians, 3 dentists, 3 registered nurses, 2 pharmacists, and 43 persons in the various categories of volunteer workers. Casualty Clearing Stations are defined in the State plan as "... established points to which casualties will be transported from First Aid Stations and where walking casualties will be received. At these

stations casualty teams, including physicians, will treat and process casualties to hospitals, homes or other dispositions."

A table of organization for emergency hospitals has been prepared and issued. This table calls for a staff of 364 persons to staff a 500-bed emergency hospital, and 621 to staff a 1000-bed hospital. All types of personnel making up the usual hospital staff are required, supplemented by many volunteer workers. The ratio of personnel to beds is considerably lower than is normally found in a hospital for the reason that it is expected that all personnel will be on duty 12 hours per day, 7 days per week for the extent of the emergency.

It is quite apparent, then, that professional personnel in all categories are needed to complete the Civil Defense organization. Professional people who are not actively engaged in the practice of their professions are also needed. In addition to the professional personnel, great numbers of volunteers must be trained and assigned. Some progress has been made but practically all aspects of Civil Defense will have to be accelerated.

BUILDINGS

Buildings, like people, are existing resources which are limited to the number available. Since buildings cannot be constructed for Civil Defense purposes, it is incumbent upon Civil Defense administrators to improvise existing buildings for use as facilities needed to carry out the Civil Defense functions. Under Medical Services, buildings are needed for use as Casualty Clearing Stations and Emergency Hospitals. Minimum standards for buildings to be converted to these purposes have been prepared and issued. In most areas commitment for the use of buildings for Civil Defense purposes has been obtained and the buildings have been assigned to specific units. The progress is setting up organizational units to staff these assigned buildings is largely in the initial stages. Local Directors of Medical Services have been urged to expedite their recruitment and training programs so that staffs can be organized to function in the assigned buildings.

SUPPLIES

The supply question presents perplexities. Funds are not available at local, State or Federal levels for

the purchase of all supplies which may be required. If funds become available in sufficient amounts for all states to satisfy their estimated needs, the vendors of supplies could not meet the demand. Most such suppliers are having difficulty meeting current demands for their products, to which have been added the defense demands. Because of this situation at this time, purchasing and stockpiling at the local level is limited to only emergency or first aid supplies. A plan has been discussed, which would establish depots of supplies at strategic points throughout the nation. Such depots would be located within four hours of all primary target areas. This is based on the assumption that four hours would be required to recover from the initial shock sufficiently to activate the Civil Defense organization beyond the First Aid Stations, the Casualty Clearing Stations and the expanded capacity of existing hospitals. Congress appropriated \$50,000,000 for such stockpiling and purchasing is now in progress.

Federal funds in the amount of \$314,000 have been made available to Maryland on a dollar for dollar matching basis for first aid supplies, blood plasma and antibiotics. The necessary matching State and local funds have been provided. A list of first aid supplies have been prepared and is under negotiation with Federal authorities for concurrence and purchase. The list includes those supplies which will be needed for the operation of Casualty Clearing Stations and their satellite First Aid Stations. Funds available for first aid supplies make possible the purchase of 150 units. These units will be allocated to Baltimore City and the 23 counties. They will be packaged in such a way that if they are not needed for local use they can be conveniently transported to a point of need.

Plasma and antibiotics will be stored with hospitals throughout the State. Storage in hospitals will permit the rotation of such perishables, thus avoiding loss from deterioration.

It can be reported, therefore, that considerable progress has been made toward organizing and developing Civil Defense Medical Services. Plans are in a satisfactory state of development. The organizational units are in the formative stage. It is expected that within a reasonable period of time Maryland's Medical Services for Civil Defense will be organized to a degree that in case of enemy action they

should be able to function effectively. No assurance, however, can be gained from this statement until organization and assignment have been completed.

NOTE. During the period since Medical Services for Civil Defense was made the responsibility of the State Department of Health, the program has been developed by Mr. H. G. Fritz, member of the State Department of Health staff, applying

part time to Civil Defense activities. On December 1, General Robert P. Williams will report for duty on a full-time basis. General Williams will come to the organization with 35 years of military experience, including situations comparable to what might be expected to follow an atomic bombing. Having full time to apply to this work, it is expected that General Williams will be able to visit all of the local areas and effect an acceleration of their Civil Defense programs.

BUILDING FUND COMMITTEE

ALBERT E. GOLDSTEIN, M.D., *Chairman*

For the benefit of the members of the Medical and Chirurgical Faculty, we are very happy to give a report of the Medical and Chirurgical Faculty Building Fund Campaign.

In 1949, Dr. C. Reid Edwards, the General Chairman of the Sesquicentennial Committee of the Medical and Chirurgical Faculty, after a meeting with other members of his committee decided that some definite renovations and additions to the Library and building were necessary. A survey of the building was made, an architect was engaged and temporary drawings of the proposed outside structure were made. A finance chairman was named and he in turn named a large group of members of the Society to act with him on the committee. A number of meetings were held and wheels were set in motion to organize the Building Fund Campaign.

After careful consideration, it was decided to start a campaign to raise \$300,000. This amount was considered necessary for our additions and improvements.

Members of the Committee chose names for individual solicitation. A plan was adopted to solicit city members first. It was decided that a minimum of \$150 would be asked of each member to be paid over a period of three years. In some instances, larger pledges are being solicited.

The campaign started very satisfactorily with a contribution of five thousand dollars from the Baltimore City Medical Society and a five thousand dollar contribution from the Baltimore Obstetrical and Gynecological Section of the Baltimore Rh Laboratory, Inc. Seventeen Baltimore physicians pledged ten thousand dollars, in amounts ranging

from five hundred to fifteen hundred dollars. This gave us a grand start of \$20,000. There were many pledges ranging from one hundred fifty to three hundred dollars. The largest group met the minimum amount of one hundred fifty dollars. A smaller group who were solicited pledged between fifty and one hundred fifty dollars. The entire Committee worked very diligently and conscientiously through the entire hot summer of that year and into the fall and winter. Approximately 458 men were solicited, of whom 420 or approximately 92 per cent pledged for a certain amount. In all, better than \$70,000 was pledged in that short time.

Along about that time many important incidents occurred, the most important of which was the activity in Washington to force Nationalization of Medicine on this country. Because of the above, it was necessary to temporarily halt our campaign and to become active in the fight against Nationalization of Medicine.

We were just about to become active again in our campaign when again we were forced to discontinue our drive because of the tremendous activity and campaign of the S.P.C.A. Their attempt to exclude procurement of dogs for research, posed a serious threat to the medical schools. A bitter battle was fought. We again discontinued our campaign so that we might participate in the fight by directing contributions from physicians to the newly formed organization known as the Maryland Society for Medical Research. After many difficult days and nights the Research Society won its battle. Since then, or about seven months ago, we have

again started planning for the renewal of our Building Fund Campaign.

In the meantime, there has not been complete rest for the Committee since several of us have visited many counties in order to familiarize members with our project. As yet, no definite campaign has been started in the counties. Nevertheless a few physicians have sent in pledges and checks which are surely appreciated.

In October 1951, various groups of the Committee were again assembled to renew with great vigor the solicitation of over nine hundred physicians in Baltimore City, never approached previously. So far only two hundred cards have been distributed to the Committee. A favorable report was recently brought in showing additional pledges of over four thousand dollars together with part payment checks. In the meantime, the Committee is working diligently. I would like to urge all readers to please lend courteous attention to any member of the Committee calling upon him. He is doing work for the good of the Society and for the benefit of every member. We are certain that every physician is going to do his share to the best of his ability. We are hoping each member can pledge at least one hundred and fifty dollars, payable over a period of five years if he desires. This contribution is tax deductible. With a $11\frac{3}{4}$ per cent increase in income tax, one can readily see that his contribution is not going to cost him a great deal.

The amount of money collected is going to be expended principally on the Library and to improve and enlarge the Osler Meeting Hall and other meeting rooms. It is the desire of the Committee to arrange in the new structure ample seating facilities, comfortable chairs, good lighting and acoustics, smaller meeting rooms for sectional groups, facilities for exhibitors at our semiannual and annual meetings. Improved rest rooms, air conditioning, a modern kitchen and supper room, portrait rooms and many other facilities that cannot be enumerated at the present time are also being planned. With each contribution that is made, opportunities are going to be offered to our members for establishing memorials. We are certain that many of our members will be interested along these lines.

Up to the present time we have actually collected approximately \$56,000 which is drawing interest each day.

Do you understand the value of our present building and Library? From an insurance standpoint we are appraised at a value of over \$250,000. Our Library is now considered the fifth largest medical library in the United States, carrying approximately 53,000 volumes of medical books and 22,000 volumes of medical journals. These are for use of any member of the Society wherever he may be located. In another year at the rate the Society is purchasing new books and subscribing for additional journals and binding the old ones, we will be unable to handle the situation. Part of the collected fund is to provide for ample facilities for parking of cars.

It is quite possible that after our total amount is collected it might be considered feasible to consider a new location rather than add to the present building. Every member will have a say in that direction. However, the immediate prime objective is to raise the initial amount. We can only make our campaign successful if each member in Baltimore City and in the Maryland counties will do his share by pledging some part of the amount to be raised. We are certain that the Baltimore City men are doing their share by the way they are responding. We do not question that when we start an active campaign in the counties that they will likewise desire to do their share in this great and necessary undertaking.

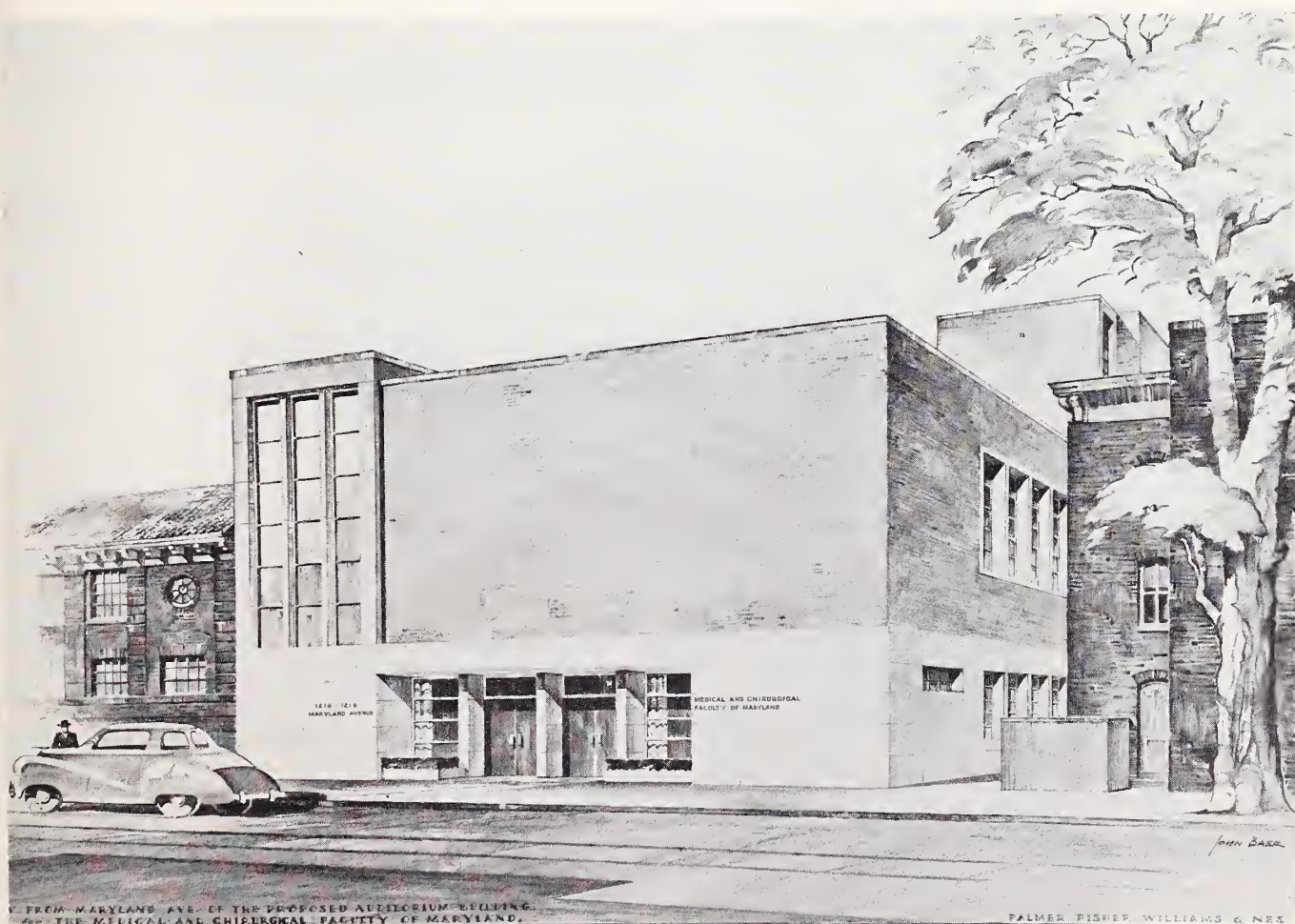
In view of the fact that each man is going to be approached, it might be well to inform our readers of the entire Committee. From this list one can readily observe that very busy men are willing to give their time in this project. Won't you please help us make this a success?

Sesquicentennial Committee (New Building): C. Reid Edwards, *General Chairman*, Baltimore; Albert E. Goldstein, *Chairman, Finance Committee*, Baltimore; John W. Parsons, *Treasurer, Finance Committee*, Baltimore; R. Walter Graham, Jr., *Chairman, Building Plans*, Baltimore.

Subcommittee—Finance Committee: Thurston R. Adams, Baltimore; Warde B. Allan, Baltimore; James G. Arnold, Jr., Baltimore; Walter A. Baetjer, Baltimore; Alan Bernstein, Baltimore; C. Bernard Brack, Baltimore; Leo Brady, Baltimore; Otto C. Brantigan, Baltimore; Henry Briele, Salisbury; Edwin N. Broyles, Baltimore; Ferdinand E. Chatard, IV, Baltimore; Beverley C. Compton, Baltimore; Newland E. Day, Baltimore; Louis C. Dobihal, Baltimore; Louis H. Douglass, Baltimore; Monte

Edwards, Baltimore; J. M. T. Finney, Jr., Baltimore; Wetherbee Fort, Baltimore; Francis J. Geraghty, Baltimore; Thomas K. Galvin, Baltimore; Mark E. Gann, Baltimore; Robert W. Garis, Baltimore; Lewis P. Gundry, Baltimore; Alan F. Gutmacher, Baltimore; Louis P. Hamburger, Sr., Baltimore; H. Hanford Hopkins, Baltimore; Harry C. Hull, Baltimore; J. Mason Hundley, Jr., Baltimore; Robert L. Jackson, Baltimore; Page C. Jett, Prince Frederick; Hugh J. Jewett, Baltimore; Marius P. Johnson, Baltimore; Walter L. Kilby, Baltimore; E. Paul Knotts, Denton; Amos R. Koontz, Baltimore; Edward F. Lewison, Baltimore; E. T. Lisansky, Baltimore; Perrin H. Long, Baltimore; Helen I. Maginnis, Baltimore; W. Kenneth Mansfield, Balti-

more; Erwin E. Mayer, Baltimore; Karl F. Mech, Baltimore; Waldo B. Moyers, Mt. Rainier; W. Raymond McKenzie, Baltimore; Samuel McLanahan, Baltimore; Emil Novak, Baltimore; Frank J. Otensek, Baltimore; Daniel J. Pessagno, Baltimore; Esther L. Richards, Baltimore; Harry M. Robinson, Jr., Baltimore; Alexander J. Schaffer, Baltimore; Fred B. Smith, Baltimore; Howard C. Smith, Baltimore; Richard W. TeLinde, Baltimore; Edward P. Thomas, Frederick; W. Houston Toulson, Baltimore; I. Ridgeway Trimble, Baltimore; Henry F. Ullrich, Baltimore; Lawrence R. Wharton, Baltimore; Walter D. Wise, Baltimore; Austin H. Wood, Baltimore; Alan C. Woods, Baltimore; Israel S. Zinberg, Baltimore.



PROJECTED BUILDING FOR THE MARYLAND AVENUE ENTRANCE

Scientific Papers

MIDCENTURY CHALLENGE

A. AUSTIN PEARRE, M.D.

Presidential Address¹

Innumerable thoughts have been expressed to the Medical and Chirurgical Faculty that deserve a fate much more worthy than oblivion. It is proposed from time to time to abstract certain of the addresses presented before the Medical and Chirurgical Faculty. It is believed that the abstracted address of Dr. Pearre is representative of a timely subject. Its reading should eliminate mental platitudes and inspire the active interest of all.

Thomas Jefferson had ideas, and if he was not a prophet, he certainly gave his fellow countrymen advice which could well be used at present, 150 years later.

Some excerpts from his inaugural are timely and deserve perpetuation in the history of our country.

"With all these blessings, what more is necessary to make us a happy and prosperous people? Still one thing more, fellow citizens—a wise and frugal government, which shall restrain men from injuring one another, which shall leave them otherwise free to regulate their own pursuits of industry and improvements."

"... Economy in the public expense that labor may be lightly burdened ... the honest payment of our debts ... They should be the creed of our political faith ... the touchstone by which to try the services of those we trust, and should we wander from them in moments of error or alarm, let us hasten to retrace our steps and to regain the road which alone leads to peace, liberty, and safety."

Mr. Jefferson's principles and policy were so popular that Congress passed an act for redeeming the public debt.

¹ Annual Meeting, Medical and Chirurgical Faculty, April 25, 1950.

It is interesting to ponder on the reaction of the statesmen of that era, could they have foreseen that 150 years later their country would be burdened with a national debt of 258 billion dollars and an annual budget proposal of \$42,435,000,000, representing additional deficit spending at the rate of over 5 billion dollars per year.

The first half of our present century has been referred to as those "terrible, wonderful years." These have certainly been the Golden Age of Medicine.

In moulding the history of our times, however, the medical profession must certainly share the world stage with other branches of science and technology. Indeed our military leaders deserve the spotlight. From the standpoint of the public, however, the man of our century may turn out to be the politician, if present trends are allowed to continue.

The years since 1900 have been marked by social restlessness. An editorial in the *New York Times* of January 1, 1950, points out—"There is a connection between the restlessness and scientific advance. Airplanes, automobiles, electron tubes, radiotelephonic communications and broadcasting, television, radar, synthetic rubber, ... the release of atomic energy—we saw these evolve before our very eyes. Labor-saving machines in mass production are being used more and more."

"Most of our economic and labor problem, are the direct result of technologic innovations and technologic innovation in turn springs from scientific research." Electronics and relativity may play even a greater role in the future, and

one shudders at the mere mention of the words "hydrogen bomb."

With such obvious reminders as the development of aviation, we are necessarily made to think of our globe as becoming smaller and smaller. As the world becomes smaller, the individual looms larger. His individual welfare must indeed be given more and more consideration.

No one can deny that in these past 20 years there has been a rapid trend toward the centralization or nationalization of power, not only in European countries, but in the United States.

As we try to analyze the factors which have created conditions leading to a so-called "welfare state," while it is certainly true that much influence in this direction has arisen from Russia as an aftermath of Marxian philosophy, and also from Germany as a result of ramifications arising from Bismarck's militaristic superstructure and policy of "Germany for the Germans," we must not lose sight of the fact that trends in this direction have been slowly evolving on this side of the Atlantic, too.

Many of you physicians who are here tonight will probably remember that before the last century ended there were periodic outbursts calling for the expansion of the social functions of the state. You may recall Mr. William Jennings Bryan's efforts and his Cross of Gold speech in 1896. Later came President Theodore Roosevelt and his "Square Deal." In 1900 Mr. Samuel Gompers was developing his American Federation of Labor to counteract the power of big business.

In the early years of the century emphasis began to be placed in these United States more and more on quantity and material progress. Everything was to be bigger and better. The development of the automobile industry showed the trend of our industrial growth.

Mr. Taft's 61st Congress was the first to recognize the principle that the great corporations could be taxed.

The first graduated tax on individual incomes

to stick, authorized in the 16th Amendment, became part of the tariff law in 1913.

We became accustomed to depend on Britain as the banker, educator and policeman to the world.

In Germany with the subsidence of the Franco-Prussian War, the enormous increase of the class of factory workers attendant on the rapid development of Germany into an industrial state, and the growth of radical doctrines among their ranks, made Bismarck see that new measures would be necessary. He thought it wise to offer the workmen permanent economic advantages through state guaranteed insurance against sickness, accidents, old age and disability. He wanted to show them that they might expect substantial advantages from the existing form of the state.

In 1911 both Great Britain and Russia adopted compulsory health insurance and other parts of Bismarck's plan.

During the active span of the lives of most of us here tonight, we have seen the world shaken by the two most catastrophic wars of all time.

World War II has also been followed by general restlessness and lack of confidence. At the present time more and more people seem to require sedatives or alcohol in order to keep going. Observe the mounting tension as we daily drive in traffic.

War, of course, provides a fertile soil for the roots of taxation. "The most important economic aspect of income taxation is naturally its effect upon the capacity and psychology of the taxpayer, for these may affect his willingness to work and to save, and thus have important reactions upon national production."

There can be no objection to paying a debt incurred in the defense of our country against Germany and Japan. This is the very least we can do. Deficit spending to the tune of 5 billion dollars a year in peacetime, however, must be stopped, since nearly all of this excessive expense arises from so-called "non-war connected domestic functions." Today, you and I devote nearly one-third of our working time and effort to supporting our Federal, State and local

governments. Tax rates on personal and corporation incomes have more than tripled in the past 20 years. One amazing feature of our present tax system is that in some instances we pay taxes to the Government only to have the Government bring our tax dollar back to compete with us at home.

Mr. Earl Bunting of the National Association of Manufacturers, tells us that we are no longer able to invest some 20% of our gross national product in new tools and machines.

Remember that without Mr. Ford's millions plowed back into his business, there would be no 60,000 jobs at River Rouge!

Since the last election in which Mr. Truman became President in his own right, the "Fair Deal" really is becoming a delusion of grandeur. It has been formally unveiled before the 81st Congress, and at its second session, federal aid to education, compulsory health insurance, expanded social security, the farm parity program (Brannan Plan), etc., add form and substance to the "welfare state." Senator John L. McClellan has estimated that 15 of the major proposals now before Congress would add within the next 4 to 5 years an additional 25 billion dollars per year to our already deficit spending yearly budget of 42 billion dollars.

"To alleviate such evils as irregular employment, inadequate income and other manifestations of maldistribution, we are now asked to expand our social security system to provide a floor of protection for all."

The recommendations for the program proposed are definitely compulsory on the individual and to be administered primarily by the Federal Government at tremendous expense. The effect on the national economy of meeting the cost is completely ignored. While there exists hardly a doubt as to the desirability of social security as a principle, according to Mr. Gerhard Hirschfeld, of the Research Council for Economic Security, "the cost may become so high as to render impotent the productive genius which is the foundation of our economic system."

In the past, security has meant ability to

work hard and ambition to get somewhere. Today people have come to think of security in terms of safety without a struggle, of freedom from worry, of protection against sickness, unemployment, old age. Private financial security is the reward of enterprise; public financial security takes its concept from the failure to create a steady income, (which is not necessarily one's own fault). We all know that insecurity frequently arises from the neglect to budget expenditures, from the unwillingness to sacrifice some leisure and pleasure for a program of hard and constructive work, and finally from a readiness to rely upon others for economic support or assistance. "In good times there is very little unemployment that is not voluntary." Members of the Faculty, we are confronted with a new epidemic disease. *The Virus of Welfaritis is destroying the life blood of Democracy and is leading to the anemic state of socialism.*

Too many of us are asking the Federal Government to do for us what our grandparents would have done for themselves.

Thousands of years ago, Cain asked the Lord, "Am I my brother's keeper?" Throughout all the period of civilization that has followed, we still must ask how far can we help a brother in need without adding to his dependence. Algernon Sidney has said that "God helps those who help themselves." Shakespeare tells us "it is not enough to help the feeble up, but to support him after."

Certainly idleness is always bad, and I often wonder how long the formula of more pay for shorter hours will work. Is it possible to create a surplus on a 40-hour week? Can more money for less work be eventually as dangerous as an atomic bomb? Perhaps being able to produce more with less effort may be the product of modern efficiency, but somehow I still admire our older generation, who desired through their spirit of free enterprise, to work long hours, and to have the benediction of the village blacksmith pronounced on their day's effort—"Something accomplished, something done; he has earned a night's repose!"

Dr. Charles R. Brown, former dean of the Yale Divinity School, once answered this question, "Am I my brother's keeper?" with an emphatic "No!" Then he added, "I must be my brother's brother." This recognizes his right to be himself, his desire to be a free agent. This attitude respects our brother's self-respect.

Freedom itself must be defined. When you speak of freedom, are you thinking of freedom from or freedom for? Freedom from may be very selfish, whereas, freedom for—being free to serve, implies the assumption of responsibility which should be every normal person's desire. The acceptance of any freedom should carry a moral obligation on the part of the recipient that he will not abuse the privilege of that freedom.

Franklin B. Snyder, President of Northwestern University, in a "Charge to the Graduating Classes," said:

"I hope that fifty years from now freedom will still exist in this land of ours. I hope we shall not have been enslaved by either an all-powerful Federal Government in Washington, or by debt, much of it incurred in the name of a vague concept called 'security', which will inevitably crush all initiative. . . . The concept of freedom which we Americans cherish is a many-sided one. It implies freedom to fail as well as to succeed."

CRADLE TO GRAVE

Our social planners would like to remove all elements of conflict, of struggle, of hazard, from life; they would extend security as proposed by Sir William Beveridge, "from the cradle to the grave."

As Mr. Justice Holmes put it "security is generally an illusion." "Slavery imposed by a planned economy can be much worse than that of poverty or disease." We are repeatedly being warned by a few very excellent governmental diagnosticians.

Mr. Herbert Hoover, on his 75th birthday, declared in an address at Stanford University, that "through Government spending and taxes, our nation is blissfully driving down the back road to collectivism and is on the last mile."

Senator Byrd in his speech on October 12th, at

Atlantic City, warned again of our deficit spending. He certainly gave every thoughtful American reason for serious contemplation when he said, "every time your watch ticks while I am making this speech, the Federal Government will be spending \$210 more than it takes in." This adds up to over 18 million dollars a day that our Government, in a peaceful year, is going farther into debt, and yet the Administration continues its attempts to expand a radical social security program. Should we not all listen to the warning of the Senator from Virginia when he states that "America is on the march to socialism, and the pace of the march is increasing to the tempo of expanding federalized programs and increasing national debt."

Truly, as Mr. Babson states, "We in the U. S. need to be acquainted with the economic facts of life."

Senator Byrd has further warned that Marxist socialism and our welfare state program are "twins of evil" and we must fight them. Members of the Faculty, we now are able to recognize the signs and symptoms of these new diseases, although their onset has been very insidious. *We know that the best social security is that which comes from a steady job, hard work and good wages.* "In order to provide this highest type of social security, it is necessary to create the conditions which are conducive to a full productive economy." A reduction in the number of working hours means that even a higher scale of wages causes no appreciable rise, if any at all, in net income. "We shall never progress by placing a premium upon idleness while putting a damper on enterprise."

If people are allowed to work more productively, they are able to save more for their individual futures. Dr. Osler has reminded us that work is the master key to success. This was true in 1900 and it is still true in 1950.

The physician here at mid-century, in addition to being a good doctor, now finds it necessary to be a crusading citizen. This has not been easy for him to do because he has always, in the past, innately shunned publicity. It is, however,

possible for us as physicians to assume this new duty since such an effort is required to meet the threat of epidemic "welfaritis." All physicians are trained to meet emergencies. Individual effort on the part of doctors is our weapon against this spreading disease and we can expect no help from antibiotics or from hormones.

We must be constantly mindful, with David Hume, that liberty of any kind is seldom lost all at once.

We cannot close our eyes or turn our heads away while politicians destroy our system of free enterprise which has made America the greatest nation in the world, and the only nation in the world strong enough to give real aid to the rehabilitation of other nations weakened by war.

We must remember that there are two ways in which liberty can be lost. It can be taken from without, and twice during the first half of our century it has been necessary to resort to stupendous war efforts to preserve our freedom. Remember, however, that liberty can also be lost through forces from within.

The chief difference between socialism and communism is that liberty dies a little more slowly under the influence of socialism.

When we read of the rapid spread of communism, isn't it urgent for every citizen living in a democracy to do some real thinking?

Is it significant that in January, 1945, Moscow ruled 190 million human beings, and that by November, 1949, she ruled 800 million of the world's people—one-third of the human race?

Physicians here and now must take an active interest in government and in world affairs. It is certainly a responsibility of ours, as American citizens, to choose, with care and thought, those who represent us in government. It is further necessary for us to keep ourselves informed as to current problems and we have every right to expect our legislators to conduct themselves as statesmen. It is vital that our representatives should think more of the next generation and less of the next election.

I believe that the average physician, as we pause at mid-passage of this momentous century, feels privileged to share achievement with the scientist and the militarist. Experience abroad, however, has shown that the politician and the bureaucrat should never come between the doctor and his patient. We insist that politics must be kept out of the science of medicine.

In our time, we have seen that wars have created as many problems as they have solved. In looking into the future we, as citizens, must all recognize that our first major responsibility is to do everything in our power to aid in securing world peace. This goal must be attained. We owe its accomplishment not only to those who have sacrificed so much for us in the past but to our children and those generations yet to come. Certainly we must not become anemic through internal occult bleeding. We know that free countries have been undermined from within.

Our present trend toward socialism, like many disease processes, is reversible. We must preserve Freedom and Opportunity, and while still free to serve, must put our whole hearts into hard work. Our guiding force must be not what I deserve, but how I can serve. Freedom of choice, voluntarily made by free people, makes America really the land of opportunity. We have an unmatched record of achievement under a system of free enterprise created by the American people through their own efforts.

We, in America, should give more and more thought to moral and spiritual values. Material things, though necessary, are not alone enough to satisfy man.

Our immediate challenge is to live and to practice more democracy. We must build up, once again, the energies of a free people by following the example of the beloved country doctor who, through the years, has always been willing to work harder and sacrifice more for the common good because of his love of humanity associated with the love of his work.

MEDICOLEGAL SYMPOSIUM—DRUG ADDICTION

The Medical and Chirurgical Faculty, in conjunction with the Baltimore Bar Association, has formed a joint committee with the following objectives:

1. To consider the problems of the lawyer in the practice of the legal profession wherein they relate to the doctor in his practice of the medical profession, and
2. To develop discussion of problems of mutual interest, and
3. To provide by way of open forums of the two professions, a discussion of problems of mutual interest, hoping to attain a better understanding of such problems and arriving at a solution thereof.

The idea originated in the Institute of Medicine of Chicago, and basically the Maryland Committee has patterned its activities along lines suggested by the Chicago group. A series of open forums for the interchange of information is contemplated. The first forum which discussed the problem of Narcotic Addiction was held in the building of the Medical and Chirurgical Faculty on Saturday, October 13, 1951. The joint committee is composed as follows:

The Baltimore Bar Association—Mr. G. C. A. Anderson, Mr. R. D. Bartlett, Mr. C. Barton, Mr. S. C. Berenholtz, Mr. J. Bernstein, Mr. W. L. Galvin, Mr. A. A. Levin, Mr. M. P. Smith,

Mr. A. Sodaro, Mr. J. S. Stanley, Mr. T. C. Waters. The Medical and Chirurgical Faculty—Dr. C. Acton, Dr. L. Brady, Dr. R. S. Fisher, Dr. M. S. Guttmacher, Dr. L. A. M. Krause, Dr. C. A. Reifschneider, Dr. R. C. Tilghman, Dr. I. R. Trimble, Dr. H. F. Ullrich and Dr. T. C. Wolff.

Participants in the Panel Symposium on Drug Addiction were: (1) Pharmacology of Drugs Causing Addiction. Earl H. Dearborn, M.D., Assistant Professor of Pharmacology, The Johns Hopkins University School of Medicine. (2) Criminal Prosecution of Drug Cases. Mr. Anselm Sodaro, States Attorney of Baltimore City. (3) Judicial Administration of Drug Cases. Judge Joseph Sherbow, Baltimore. (4) Care, Treatment and Rehabilitation of Drug Addicts. James V. Lowry, M.D., Chief of Community Services Branch, National Institute of Mental Health, Bethesda, Maryland. (5) The Problems Presented to the Youth of the Community by the Traffic in Drugs. Mr. Roszel C. Thomsen, Member of the Bar and President of the Baltimore City School Board.

It is believed that their remarks are extremely important, timely and applicable to the entire State. Important phases of the discussion are hereby reproduced. Additional parts will be reproduced in forthcoming issues.

THE PHARMACOLOGY OF DRUGS CAUSING ADDICTION

EARL H. DEARBORN, PH.D., M.D.

Assistant Professor of Pharmacology and Experimental Therapeutics, The Johns Hopkins University

Addiction is a term which has been used in very loose fashion in recent years; therefore, at the outset of this discussion I would like to define it as a pharmacological phenomenon. It may be said that there are three essential factors in addiction, namely, HABITUATION, TOLERANCE, and PHYSICAL DEPENDENCE.

Habitation is a state of psychic or emotional dependence in which the individual becomes accustomed to the effects of the drug and, as with all habits, suffers some mental disturbance when it is interrupted. Since this is purely a subjective phenomenon, it can be studied only in man and then only with considerable difficulty.

A great many drugs may bring about habitua-

tion. Stimulants such as caffeine or amphetamine; sedatives such as acetanilid or bromides; hypnotics such as chloral, paraldehyde, alcohol, marihuana, or barbiturates; and even such a common substance as tobacco may bring about the formation of a drug habit. However, by far the most marked degrees of habituation are produced by cocaine or morphine or various morphine substitutes. Cocaine gives a marked euphoria usually accompanied by increased activity. Morphine and its substitutes also produce marked euphoria though it is not accompanied by increased activity. Heroin gives the most marked euphoric effect of any member of this group. The euphoria caused by this group of drugs seems to be closely associated with not only their tendency to produce habituation but with their ability to relieve pain. For example, Isbell and his associates have found that l-methadon produces euphoria, habituation, and relief from pain whereas d-methadon exhibits virtually none of these effects.

Tolerance is the term applied to the situation in which an individual or animal must be given successively larger and larger doses of a drug to produce the same pharmacological effect. Tolerance does not always develop following chronic administration of habituating drugs. Chronic use of caffeine, amphetamine, acetanilid, bromides or marihuana in all probability does not result in the development of tolerance to their actions on the central nervous system. Very slight tolerance may develop after chronic use of chloral, paraldehyde or tobacco.

Although there is no conclusive evidence that tolerance to alcohol develops in man, it is widely believed that it does. Animal studies indicate that it might be demonstrable if properly controlled experiments could be carried out in man. In dogs, Newman and Lehmann measured the degree of intoxication produced by a dose of alcohol given intravenously. This was followed by a period of ninety-seven days during which the dogs were habituated to alcohol. Then the degree of intoxication following the same intravenous dose was again measured and found,

in all cases, to be significantly less than it had been before the period of habituation. This provides a conclusive demonstration of the production of a moderate degree of tolerance to alcohol in the experimental animal.

Attempts to demonstrate tolerance to barbiturates in animals have not been too successful. Occasional authors have felt that some slight tolerance to the hypnotic effect was observed, but in view of the marked variability in the responses of the same animal at different times one must regard these as probably insignificant. No tolerance to the toxic effects has been observed. Numerous reports of chronic barbiturate intoxication in man have appeared in the literature. However, it is impossible to determine whether any significant degree of tolerance exists, because of the variability in the response of any given individual at different times.

In a recent study carried out at the government narcotic hospital at Lexington, Kentucky, Isbell and associates administered large doses of secobarbital, pentobarbital or amobarbital to five former morphine addicts for periods ranging from ninety-two to one hundred fourteen days. During the early part of the period of intoxication the dose was increased somewhat, but the authors found it impossible to determine whether or not any tolerance was produced. However, readministration of the same dosage sixty to ninety days after withdrawal resulted in a much more severe intoxication than was seen during the chronic administration. In fact, it was necessary to discontinue the drug after twenty-four hours to avoid endangering the lives of the subjects, yet they had previously tolerated this same amount of drug daily for a number of days. The evidence suggests that some tolerance to barbiturates may occur, but it is not likely that it is of a very large order or magnitude.

There is general agreement among those who have studied the problem that no tolerance to cocaine has been shown in animals. Some have reported its occurrence in man; however, it seems likely that when an individual begins to take cocaine he increases the dose progressively until

he has determined the maximum dose he can tolerate. Once having determined this maximum, he may abstain for long periods and then return to the drug taking the same dose. This cannot be done with any drug to which marked tolerance is developed.

Tolerance to morphine or its substitutes can be developed to a very high degree. Light and his colleagues in their classic study record that they were able to administer *two grams* of morphine intravenously in two hours twenty-four minutes to an addict without any change in pulse, respiration or blood pressure. This dose was approximately nine times his regular dose and is around one hundred times the amount that could be given to a normal individual. Tolerance to morphine or one of its substitutes confers some degree of cross-tolerance to other members of this group.

In rats and dogs, tolerance to the analgesic and general depressant actions of morphine and its derivatives and methadon is readily developed. Tolerance to the depressant action of meperidine has also been demonstrated. In these and other lower animals death from morphine or its substitutes results from convulsions. No tolerance is developed to this lethal action of morphine, and it seems likely that this would also be true of meperidine and methadon. In monkeys and man, stimulation is less marked and death when it occurs is due to respiratory depression; hence, tolerance to the lethal effect develops along with tolerance to the general depressant effect.

Tolerance need not be associated with psychic or physical dependence. For example, the body tissues may become tolerant to nitrites which do not produce either type of dependence.

Physical dependence is the state in which the body has become so accustomed to the presence of the drug that it cannot carry out its physiological activities in a normal manner without it. When the addict is deprived of drug and its effects begin to disappear, physical dependence is manifested by the abstinence syndrome, otherwise known as withdrawal symptoms. Physical dependence either is not known to

occur or is insignificant after the use of caffeine, amphetamine, bromides, acetanilid, chloral, paraldehyde, marihuana, tobacco or alcohol. Physical dependence to cocaine is much less than with morphine.

With barbiturates irritability and convulsions have been observed in dogs, but no symptoms have been seen in monkeys on termination of periods of chronic intoxication with barbiturates. There are a number of descriptions of the occurrence of psychoses or convulsions or both in patients deprived of barbiturates after periods of chronic intoxication. The best description is given by Isbell in his exhaustive study of five former morphine addicts. On withdrawal of the drugs, the signs of intoxication were superseded in twelve to sixteen hours by weakness, tremor, anorexia, nausea and vomiting, rapid weight loss, increase in pulse and respiratory rates, fever, and increase in blood pressure with difficulty in making cardiovascular adjustments when standing. Frank psychoses resembling delirium tremens were seen in four of the five patients and convulsions resembling grand mal epilepsy were seen in four of the five. The symptoms were at their worst from thirty-six hours to five days, following which they gradually declined in severity, and by sixty days recovery was complete.

Symptoms of physical dependence to morphine or its substitutes following withdrawal are as follows. At first, only mild symptoms such as perspiration, runny nose, excessive flow of tears and yawning are seen. These become progressively worse and gooseflesh, dilation of the pupil, loss of appetite and muscular tremors appear. Then insomnia, restlessness, increased rate of breathing and elevation of the blood pressure develop, and as the syndrome reaches its fully developed state vomiting, diarrhea and weight losses as high as fifteen pounds in twenty-four hours may occur. This is a strenuous ordeal and may culminate in collapse and shock even in healthy individuals. In an aged or infirm addict withdrawal of the drug may result in death. This fact is recognized

in the Harrison Narcotic Act. With morphine or heroin these symptoms increase during a period of thirty-six to forty-eight hours after which the severity decreases. Five to seven days, after the last dose of drug only nervousness, insomnia and weakness remain. These gradually disappear over a period of several weeks to six months. Withdrawal symptoms resulting from discontinuance of meperidine are less severe than those from morphine, reach maximum intensity more quickly, and disappear more rapidly. Those from methadon withdrawal are less severe but much more prolonged than those of morphine, and those from codeine are quite mild.

Physical dependence has been produced in a wide variety of animal species but only in the dog and monkey are the withdrawal symptoms sufficiently similar to those in man to make them of value in studying drugs of this general type. Withdrawal of codeine or meperidine does not cause symptoms in dogs though they occur following methadon withdrawal. In monkeys, codeine gives minimal symptoms and meperidine and methadon essentially none. It is obvious that studies of physical dependence in animals are of limited value.

In man the establishment of a diagnosis of addiction rests upon the demonstration that withdrawal symptoms occur on stopping the drug and on their disappearance upon readministration of the drug. It has been found that individuals addicted to morphine or one of its substitutes can be relieved of withdrawal symptoms at least in part by administration of other members of this group. It is the general feeling that any drug which will relieve the abstinence syndrome of morphine is at least potentially an addicting drug; hence, it is the present custom to consider it so until evidence to the contrary is presented. In the past, many new drugs have been introduced for the treatment of pain, and in each case the claim has been made that they are not addicting. However, the above test for addiction potentiality

has, in each case, been borne out by the subsequent appearance of cases of primary addiction which present themselves for treatment at the Government hospitals at Lexington and Ft. Worth. Many of the hypnotic drugs such as barbiturates may give a slight relief from withdrawal symptoms which is probably related to their depressant action, but notable relief is given only by drugs which in the end have proven to be addicting.

As I have defined it addiction is a purely pharmacological phenomenon consisting of a reaction between a drug and an organism by means of which HABITUATION, TOLERANCE, and PHYSICAL DEPENDENCE are developed.

The most serious and deleterious effects of addiction are the secondary ones which result from the imperative need of the addict to have his drug regularly. His need for drug comes to supercede all other objects in life and results in moral collapse so that he will sell any possession, steal, rob or even murder to obtain a supply. In closing, I wish to emphasize that it is not the addiction per se which is harmful to the morphine addict. When he has adequate supplies of drug, he can carry on a normal life and cannot be told from a normal individual even with exhaustive studies, as was shown by Light and coworkers. Addiction to cocaine or meperidine or habituation to alcohol or barbiturates, on the other hand, may be much more dangerous as there are usually definite signs of intoxication in those taking these drugs.

Including the social consequences of addiction in the definition of the phenomenon, as has frequently been done, serves only to confuse matters. It is akin to saying that the intoxicated individual who drives a car successfully is not drunk whereas he who has an accident is drunk. In addition, it is obvious from this discussion that there are drugs which may have socially detrimental effects which cannot be considered to be addicting.

PROSECUTION OF DRUG CASES

ANSELM SODARO, ESQ.

States Attorney of Baltimore City

Introduction by:

CHAIRMAN THEODORE C. WATERS: To the office of State's Attorney of Baltimore City is assigned the prosecution of Drug cases in our Criminal Courts. This is an essential phase of the administration of justice and when dealing with Drug cases calls for tact, discretion and determination to control the traffic of drugs. Anselm Sodaro has distinguished himself in the administration of his office and has assumed and discharged with ability the prosecution of drug cases. It is my pleasure to introduce our distinguished State's Attorney, Mr. Sodaro.

STATE'S ATTORNEY SODARO: Mr. Waters, Mr. Stanley, Dr. Wise, Ladies and Gentlemen, the Narcotics traffic is a heinous, commercial racket which thrives on the slow, painful annihilation of its victims. To quote the Honorable Harry J. Anslinger, Federal Commissioner of Narcotics, "The Narcotics peddler does not kidnap children, he destroys them." This racket must be dealt with vigorously and relentlessly. The drug problem should be the vital concern of the entire community, not alone of law enforcement officers and the Medical profession.

No greater menace to society exists than that which is presented by syndicated, commercialized narcotics operations. Manifest to all is the regrettable breakdown of the moral and spiritual life of our citizens. In too many places it is no longer regarded that the education of our young should embrace any reference to Religion.

There has been an over-emphasis on the material development of our youth at the expense of their moral training. There has been evidenced too much delegation and transfer of parental authority of our youth. Parents have been entirely too eager to relinquish this authority and responsibility. The home seems to be no longer the center of attraction and the

proper place for the moral education of our juveniles. Responsibility for any breakdown in our social fabric should be attributed to the individual home. As one eminent columnist recently said: "No matter what progressive educators say about the social value of self-expression in a Democracy, children who grow up like alley cats without moral restraint and inhibition will not resist the temptations of their environment. These restraints and inhibitions must be developed in the home."

The dual problems of organized crime and juvenile delinquency have a common cause in that there is present an alarming indifference to the accepted moral standards. It has always been my belief that full exposure of the nature of the problems to be dealt with is imperative if we wish to administer corrective measures. It is clear therefore, that this deterioration of moral values has brought about an increase in juvenile delinquency and criminality, and has given encouragement to the heartless miscreants who profit out of the distress and misery of their unsuspecting victims.

Prior to 1945 there were in our country very few individuals below the age of twenty-one under investigation in connection with the use of narcotics. By 1946 the situation was changing and three per cent of the addicts treated by the U. S. Public Health Service Hospital at Lexington, Kentucky, for the cure of Drug addiction were under twenty-one years of age. Today, eighteen per cent are under twenty-one years of age. Most of these are the juvenile delinquent type, the High School student being the exception. These young people associating with criminals, begin to smoke Marijuana and then graduate to Heroin. Money to purchase Narcotics necessary to maintain addiction is usually obtained through criminal activities. Traffickers sensing the rise

of juvenile delinquency have turned to the juvenile delinquents as a source for victims.

Through the combined efforts of local and Federal law enforcement officials, substantial progress has been made against this corruption. In March, 1951, the Mayor and the Board of Estimates allocated Ten Thousand Dollars to the State's Attorney's Office to be used in the fight against narcotic traffic.

For the first time a Narcotics Squad has been established within the Police Department to concentrate on Narcotics violators. This Police detail now permits local agents of the Federal Bureau of Narcotics to concentrate their major efforts on traffickers. These agencies are waging a successful war against illicit dealers. Investigations take them into the underworld, the opium smokers den, the sordid and forbidden haunts of the drug addict and the office of the Doctor who has prostituted his profession by issuing illegal prescriptions for drugs. These officers are especially trained. They deal with informers and addicts. They have become experts in searching for drugs cleverly concealed in the walls of houses, furniture, hollow heels of shoes and in numerous other places known only to the wily and crafty, schooled in the ways of the criminal.

Criminals engaged in illicit Narcotic Drug traffic are desperate characters. The lives of officials are always in danger while taking indescribable risks in defense of society against the onslaught of this criminal conspiracy. The concerted efforts of authoritative agencies supplied with money from the State's Attorney's office have brought about excellent results in combatting this traffic. From January until September of 1950, only forty-eight narcotics cases were prosecuted in the Criminal Courts of Baltimore with sentences ranging from sixty days to two years. For the same period this year, one hundred and thirty-five cases have been prosecuted in the same Courts. A breakdown of these cases discloses that eighty-five defendants were colored, thirty-two were white;

ninety-eight were males and nineteen were females. Nine cases were under twenty-one years of age. Sentences have ranged from three months in jail to ten years in the Maryland Penitentiary. This breakdown indicates that drug addiction is not too prevalent among those under twenty-one years of age and I think should eradicate any foundation for hysteria.

Narcotics have become more difficult to obtain in Baltimore City. The price of these illicit drugs have been tripled. Many known peddlers are no longer operating here and have moved to other localities, principally Washington. Baltimore City has never been a source of supply but has been and is now a "victim city" between New York and Washington. I do not want to convey the impression that we are not still confronted with a serious situation worthy of our best efforts. Pressure should and will be continued against these traffickers.

One of the principle reasons for Narcotics traffic and addiction having flourished was the fact that peddlers were not severely dealt with by the Courts. It became apparent that little could be accomplished without the support of the Judiciary. Penalties for violation of the Narcotics laws had to be increased so as to furnish the Courts with a real weapon against the peddlers. Accordingly, the Legislature in its last session responded by fixing the penalty for second offenders at not more than two thousand dollars and imprisonment for not less than five years nor more than ten years; and the third offenders a fine of not more than three thousand dollars and imprisonment for not less than ten years nor more than twenty years. Legislation was also enacted making it a felony to sell and dispose of narcotics to minors and fix the punishment by imprisonment for a term of not less than five years and not more than twenty years.

Furthermore, the Legislature granted the State the right to seize all vehicles used in the transportation and concealment of narcotics. Since the time these statutes were enacted in

News Letter

American Medical Association Dues—Deductibility for Federal Income Purposes

The following is quoted from a letter from Mr. J. W. Holloway, Jr., Director, Bureau of Legal Medicine and Legislation, American Medical Association: "It is a general rule that dues to professional organizations constitute an ordinary and necessary professional expense and while there has been no specific ruling emanating from the Office of the Commissioner of Internal Revenue relative to the deductibility of American Medical Association dues, I personally feel that the general rule should apply. It is true that in connection with the assessment levied in 1949 the Office of the Commissioner declared it to be nondeductible but there were issues involved there which do not obtain now. With respect to the assessment, it was generally publicized that payment was not obligatory and that the money collected would be used principally, if not solely, in opposition to compulsory sickness insurance. In the viewpoint of the Commissioner the money was paid and was used for lobbying purposes and as such did not constitute a deductible expenditure on the part of physicians. There is a general rule that amounts expended for lobbying purposes by an organization do not constitute deductible expenses incurred by the organization and the Commissioner apparently argued from this that funds donated to be so used can not be deducted by the donors.

"In the present instance, the payment of dues is obligatory and the funds collected will be used for the necessary functions and activities of the Association, including the substantial contribution that the American Medical Association is making to the advancement of medical education. Too, a physician in paying his dues to the Association receives without further cost a subscription to the Journal. In my judgment, a physician would be justified in claiming as a deduction the dues paid to the Association."

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Practical Nurses

There are now 179 organized training programs for practical nurses in the United States and its territories.

Of these, 103 are conducted under vocational education auspices in 29 states, the District of Columbia and Hawaii; the majority of the remaining 76 programs are operated by hospitals. One year ago the situation was just the reverse—most of the training programs were conducted by hospitals. In all but four states practical nurse training programs of some kind have been inaugurated. In 1950 the 179 training programs graduated approximately 5400 practical nurses; "about one-third of the 15,000 practical nurses needed annually for several years to build this force to the desired strength."

Training varies; the average program is one year long, although some states have programs of nine and eighteen months. The curriculum usually follows the pattern of professional nursing; a three or four month preclinical program of instruction followed by a clinical period of approximately eight months. Most courses are given on an adult education level. In the few programs offered in senior high schools, the in-school or preclinical portion of instruction is provided in the latter part of the senior year with clinical experience immediately following. The programs are financed by both private and public funds. Federal money is made available through the Smith-Hughes Act of 1917 and the George-Barden Act of 1946 which provides for the promotion of vocational education in the states.

—Chronic Illness News Letter, October 1951.

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Three-point Plan for Rehabilitation of Drug Addicts

CHICAGO—A three-point plan for long-term regional counseling and rehabilitation clinics for youthful narcotic addicts was given by Dr. Leonidas H. Berry, Chicago, in the current (Nov. 17) Journal of the American Medical Association.

Not only will the clinics offer longer periods of medical supervision for effective rehabilitation of the addicts, but will also prevent many persons with the tendency to become addicts from doing so, Dr. Berry said.

Point one under the proposed plan is medical prevention. Youths who have not become too greatly addicted would be weeded-out and encouraged to come to a clinic to receive counseling against the tragedy of greater

addiction. They would be given physical examinations, psychiatric screening or detailed psychiatric tests, vocational or occupational counseling and other types of treatment.

These youths would be referred for counseling by school principals and teachers, school psychiatrists, truant officers, welfare agencies, churches and courts of law.

"Many young drug addicts are free in the larger communities, groping for help outside the law," Dr. Berry stated. "Many parents of drug addicts are looking for help for their children and would gladly cooperate to get them into the hands of physicians before they get into the hands of the law. Victims helped by the clinic would undoubtedly send in their friends."

Those youngsters found to be too far advanced in the drug habit would be aided in finding adequate withdrawal treatment. Thus, the doctor said, sources of infection and reinfection for potential addicts and other susceptible persons would be identified and removed from the community.

"Far-reaching community contacts and the cooperation of a large number of civic institutions and organizations, public and private, would be necessary for successful operation of this plan," Dr. Berry stated, "But, the threat of social disintegration of a large segment of the youthful citizens more than justifies the magnitude of the effort."

The second point of Dr. Berry's plan is the establishment of medical counseling clinics, which would be attached to existing out-patient departments of strategically located hospitals. Complete physical and psychiatric examinations would be given each addict visiting the clinics. Treatment as needed, vocational counseling, job placement and recreational programs would be included in the services of the clinics.

The third point of the proposed plan is a medical follow-up program. This phase would enhance the effectiveness of hospital withdrawal care with long-term rehabilitation of drug addicts.

Upon discharge from hospitals or penal institutions, addicts would be persuaded to attend one of the counseling clinics. Here they would be given specific treatment toward breaking the drug habit completely. Today, four out of five addicts return to the use of drugs following such releases.

"Narcotic addicts discharged as cured from hospitals and penal institutions, unsupervised as they usually are, are a continuous source of contagion to other susceptible persons," according to the doctor.

The number of clinics, he said, would depend upon local needs. Funds for their operation might be provided by federal, state, county, municipal or private grants. The implementation and supervision of the regional group of narcotic clinics could be handled by a working sub-

committee of about 12 technical experts who would be representative of a much larger advisory board. This board should consist of representatives of welfare organizations; employment services; school boards; religious, business and industrial organizations; courts of law, and press relations.

Narcotic addiction among adolescents and young adults has reached epidemic proportions in some areas, Dr. Berry stated, adding:

"There is extensive evidence that the drugs are distributed by an organized underworld system reaching outside the continental United States, with its terminals located primarily in the poorest and most densely populated communities.

"The very nature of adolescence, with its instability of personality, underdeveloped poise and will power, and abundance of adventuresomeness, curiosity, and courage offers a degree of susceptibility to drug addiction.

"Ultimate control of the drugs at the distribution level is seen as the final stroke which may destroy the epidemic nature of the problem."

* * * * *

Nationalized Medicine in European Countries

The Illinois State Medical Society, Chicago, Illinois

Dr. Edwin S. Hamilton of Kankakee, Ill., and Dr. J. J. Moore of Chicago, in a joint statement issued October 22, 1951, sum up their European observations of the last summer as follows:

"The broad picture, as outlined at the World Medical Association meeting in Stockholm, is one of the state medical care systems generally more or less acceptable to the mass public, but not at all to the medical profession.

"The importance of that distinction lies in the fact that the European masses are content because they do not know what they should expect and think they are getting a good thing for nothing. What it really amounts to is something good for nothing.

"The medical men, in vivid contrast, know what could be done without government interference and how far they fall short of their possibilities. That is why they are unhappy with national medicine.

"At the same time, people who can afford it and know good care go to the few remaining private practitioners when they need medical or dental care, disdaining the state systems. We are certain the American people would never accept such a lowering of their medical care quality."

Socialization of Insurance

Insurance Economics Surveys, a monthly review of the social security scene, prepared by the Insurance Economics Society of America, states the following:

"U. S. Delegate Reveals Global Deal: A member of the United States delegation reported yesterday that socialization of life insurance in the United States would be required by a global treaty given preliminary approval by the International Labor organization's June conference in Geneva, Switzerland. The treaty or convention would 'completely change the world's insurance system,' said William L. McGrath of Cincinnati, Ohio, president of the Williamson Heating Company, in his official report. For three years McGrath has attended I.L.O. conferences as official adviser to Charles P. McCormick of Baltimore, Md., the employer delegate from the United States. McGrath predicted that the 1952 conference would give final approval to the global scheme."

* * * * *

Four-group Commission to Accredit Hospitals

CHICAGO—The Journal of the American Medical Association announced on October 19, 1951, the establishment of a joint commission representing the American Medical Association, the American Hospital Association, the American College of Surgeons and the American College of Physicians for the accreditation of hospitals in the United States and possibly Canada.

The joint commission will be composed of 18 members: six appointed by the American Medical Association, six by the American Hospital Association, three by the American College of Surgeons and three by the American College of Physicians.

While the plan for establishment of the joint commission has already been approved by the four organizations, none of the 18 members have yet been selected. They will be appointed within a short time. The commission hopes to be in operation by January 1, 1952.

A minor change in the representation will be made if the Canadian Medical Association accepts an invitation to participate. In this event it will appoint one representative and the American Hospital Association will appoint an additional member from the Canadian hospitals, making the total commission membership 20.

The Commission, which will take over the work carried out by the American College of Surgeons for more than

25 years, will be financed by the constituent organizations on a basis proportionate to their representation on the commission. The budget for the first year of operation has been tentatively set at \$70,000, but this amount does not include the costs of hospital inspection service, which will be the responsibility of the individual organizations.

During the years that the American College of Surgeons successfully administered the hospital standardization program, the investment from membership dues exceeded \$2,000,000.

It is estimated that when the program actually gets underway by the new commission, the combined budgets of all four organizations will be approximately \$250,000 annually.

The functions of the commission will be to formulate standards relating to hospital accreditation, to establish the type and scope of inspections to be made under this program, to assign responsibility for hospital inspections to the several participating organizations, and to award certificates of accreditation to qualifying hospitals. Presently, there are 3,200 hospitals approved by the American College of Surgeons.

* * * * *

Army Intensifies Campaign to Enlist 2,000 More Nurses

In connection with a nationwide campaign to enlist women in the Armed Forces, Army is renewing its efforts to sign up 2,000 more nurses and 500 women medical specialists.

* * * * *

Industrial Medical Service

Council on Industrial Health of the American Medical Association

Many general practitioners accept responsibility for industrial medical service, and particularly for illnesses and injuries that are related to employment. During recent years it has been variously estimated that between 85 and 90 per cent of industrial health services have been rendered by the general practitioner. In May 1950 the American Academy of General Practice reported that a survey of their membership, relative to the "Distribution

and Type of Practice of Members", developed the following information:

1. Industrial cases cared for by 95 per cent of their membership
2. Average number of cases seen in 1948 was 234 per member
3. About 20 per cent of the membership devote full time to industrial practice.

These significant facts lead to the appointment of a joint committee by the Academy of General Practice and the Council on Industrial Health for the purpose of exploring the desirability of developing a joint program for the education of general practitioners in the fundamentals of industrial medical practice. This committee, meeting with representatives of the American Medical Association Section on General Practice, concluded that it is desirable to formulate a program and curriculum which will be implemented on a national, state and local level through joint cooperative effort of the participating groups.

* * * * *

Fellowships in Industrial Medicine

The Institute of Industrial Health of the University of Cincinnati will accept applications for a limited number of Fellowships offered to qualified candidates who wish to pursue a graduate course of instruction in preparation for the practice of Industrial Medicine. Any registered physician, who is a graduate of a Class A medical school and who has completed satisfactorily at least two years of training in an hospital accredited by the American Medical Association may apply for a Fellowship in the Institute of Industrial Health. (Service in the Armed Forces or private practice may be substituted for one year of training.)

The course of instruction consists of a two-year period of intense training in Industrial Medicine, followed by one year of practical experience under adequate supervision in industry. Candidates who complete satisfactorily the course of study will be awarded the degree of Doctor of Industrial Medicine.

During the first two years, the stipends for the Fellowship vary, in accordance with the marital status of the individual, from \$2,100 to \$3,000. In the third year the candidate will be compensated for his service by the industry in which he is completing his training. Requests for additional information should be addressed to the Institute of Industrial Health, College of Medicine, Eden and Bethesda, Cincinnati 19, Ohio.

Vacancies at the Veterans Administration Hospital, Fort Howard, Maryland

It is anticipated that there will be several vacancies in the Resident Staff at the Veterans Administration Hospital, Fort Howard, Maryland, for the year commencing July 1, 1952. These residencies are open to applicants who have completed one or more years of internship, assistant residency or residency. The salary range is \$2400 to \$3000 depending upon the previous training and/or experience of applicant. The training program is directed by the Deans' Committee of the Johns Hopkins and University of Maryland Medical Schools, and is fully approved for training for American Board of Internal Medicine certification.

Individuals interested in applying for those positions are requested to communicate with Dr. Irving Freeman, Acting Chief, Medical Service, Veterans Administration Hospital, Fort Howard, Maryland.

* * * * *

A New Appointment

The American Board of Obstetrics and Gynecology announces the election of Dr. John L. Parks, of Washington, D. C., as a member and Director of the Board. Dr. Parks succeeds Dr. Joseph L. Baer, who has been Vice President of the Board for over twenty years and who has resigned.

* * * * *

Fellowship Dues—1952

A.M.A. Secretary's Letter No. 201, November 19, 1951

Meeting at A. M. A. headquarters recently, the Board of Trustees decided there would be no Fellowship dues for 1952. Fellowships, the Board felt, are no longer required since A. M. A. members are now paying membership dues and, furthermore, the Fellowship dues requirements were too confusing to members as a whole. Fellowship dues of \$5.00 for 1951 are still payable.

the Spring of this year (1951) a number of automobiles used in the transportation of drugs have been confiscated; heavy penalties have been imposed against second offenders and defendants convicted of selling drugs to minors have been punished severely. Vigorous prosecution and longer prison terms of the drug peddler will not fully solve the problems. The addicts and users themselves must be given special attention.

It is well established that drug addiction must be considered a communicable disease. Like smallpox, drug addiction should be cared for by local Public Health authorities. The addict must be taken out of circulation until cured. Cases in our Courts clearly demonstrate that addicts are usually incapable of following legitimate occupations. They will engage in criminal activities; particularly robbery, burglary and prostitution, in order to secure money to purchase narcotics. They spread physical destruc-

tion and moral degradation in their wake and are a menace to the community.

Local and State Governments should assume the responsibility of providing hospitalization for these unfortunates. The establishment of control wards in City and State hospitals ought not to be too difficult. The medical and psychiatric aspect of the drug problem deserves the best efforts of the medical profession and our law-making bodies. It is both a law enforcement problem and a medical problem. To exert efforts on the law enforcement aspect while neglecting the medical aspect of the matter will accomplish little.

I am happy to observe that Baltimore City Administration is now taking definite steps to provide control clinics for the treatment and cure of drug addicts. Thus when peddlers and addicts are removed from our streets, a source contagion is eliminated and the general crime situation alleviated as well.

Symposium continued in next issue

SEVENTH NATIONAL CONFERENCE ON RURAL HEALTH

FEBRUARY 29 AND MARCH 1, 1952

Shirley-Savoy Hotel, Denver, Colorado

The theme of the Conference will be "HELP YOURSELF TO HEALTH." Full information may be obtained from the Seventh National Conference on Rural Health, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Component Medical Societies

BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street, Baltimore, Maryland

SAMUEL McLANAHAN, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*

J. ALBERT CHATARD, M.D., *Treasurer*

JOINT MEETING WITH THE SECTION ON SURGERY

I. RIDGEWAY TRIMBLE, M.D., *Chairman* E. RODERICK SHIPLEY, M.D., *Secretary*

Friday, February 15, 1952, 8:30 p.m.

SYMPOSIUM ON THE USE AND MISUSE OF BLOOD TRANSFUSION IN SURGERY

The names of the speakers will be announced.—*See page 33.*

Meetings

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

SECTION ON ANESTHESIA

LEONARD J. ABRAMOVITZ, M.D., *Chairman* OTTO C. PHILLIPS, M.D., *Secretary*

Monday, February 4, 1952, 8:30 p.m.

Treatment of Acute Clinical Emergencies. DONALD H. STUBBS, M.D., Chief of Anesthesiology, The Doctor's Hospital, Washington, D. C.; Clinical Professor of Anesthesiology, The George Washington University School of Medicine, Washington, D. C.; President of the Southern Society of Anesthesiologists. (By invitation.)

OPHTHALMOLOGICAL SECTION

ABRAHAM KREMEN, M.D., *Chairman* ANGUS L. MACLEAN, M.D., *Secretary*

JOINT MEETING WITH THE OPHTHALMOLOGICAL SECTION OF THE DISTRICT OF COLUMBIA MEDICAL SOCIETY

Tuesday, February 5, 1952

Dinner 6:30 p.m. Scientific Meeting 8:00 p.m.

Kennedy-Warren Hotel, 3133 Connecticut Avenue, N.W., Washington, D. C.

Subject to be announced. ALSTON CALLAHAN, M.D., Professor of Ophthalmology, Medical College of Alabama, Birmingham, Alabama.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral Street, Baltimore

MRS. H. HANFORD HOPKINS, *President* MRS. MARIUS P. JOHNSON, *Secretary*

MRS. HARRY C. BOWIE, *Treasurer*

Wednesday, February 6, 1952, 11:00 a.m.

Program to be announced.

NEUROPSYCHIATRIC SECTION

SAMUEL NOVEY, M.D., *Chairman*

JOINT MEETING WITH THE BALTIMORE PSYCHOANALYTIC SOCIETY

Thursday, February 14, 1952, 8:30 p.m.

Aesthetics as a Field for Psychoanalysis. MARK KANZER, M.D., New York City.
(By invitation.)

THE OBSTETRICAL AND GYNECOLOGICAL SOCIETY OF MARYLAND

EMIL NOVAK, M.D., *President*

W. DRUMMOND EATON, M.D., *Secretary*

Thursday, February 28, 1952

Hotel Stafford

Dinner 6:30 p.m.

Program to be announced.

PATHOLOGY SECTION

WILLIAM V. LOVITT, JR., M.D., *Secretary*

Monday, February 18, 1952, 7:30 p.m.

Program and place of meeting to be announced.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, February 21, 1952

5:00 to 6:00 p.m.

MATERNAL MORTALITY MEETING

Thursday, February 28, 1952, 4:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and
the Baltimore City Health Department.

UROLOGY SECTION

The Officers and members of the Section on Urology have proposed discontinuance
of meetings for the time being.

CHARLES COUNTY

J. PARRAN JARBOE, M.D.

Resident Physician Selected for the Physicians' Memorial Hospital

A resident physician, Dr. Mary C. T. Mullan, has been selected by the Charles County Medical Society, to serve in the 40 bed Physicians' Memorial Hospital in La Plata. This is the first and only hospital in Southern Maryland to employ a full-time resident physician and this should be the solution to many emergency medical and surgical problems arising at the hospital.

Selection of the resident physician was made by the Charles County Medical Society from a list of 74 applicants. Each applicant was considered carefully and many were interviewed personally. The final approval was made by the Executive Board of the Physicians' Memorial Hospital and the Board of County Commissioners of Charles County. The position of resident physician was made possible by a special act of the Maryland Legislature enacted in March 1951, which authorized an additional tax levy to cover the salary and expenses needed to procure the services of a full-time resident physician. There has been dire need for such a physician for many years. The recent increase in the number of major operations, obstetrical deliveries, and rapid turn over of medical patients plus the increasing numbers of emergency cases has made the need a desperate one.

Dr. Mary C. T. Mullan, the new resident physician, was born in Northern Ireland, and was graduated in December 1947 from the Queen's University, Belfast—with the Bachelor of Medicine, Surgery, and the Art of Obstetrics Degrees. She has served in the Londonderry and Mid-Ulster Hospitals as House Physician and also has done general practice in Northern Ireland. She is a member of the British Medical Association and is registered to practice medicine in Great Britain and Ireland. Dr. Mullan served a general internship at the Holy Name Hospital, Teaneck, N. J., from October 1950, to October 1, 1951. She arrived at the Physicians' Memorial Hospital on October 8, and began her duties as the first resident physician.

In a short period of only two months, Dr. Mullan has proved that a resident physician is an irre-

placeable asset to a small hospital. Her duties have been general in nature; but she has become invaluable to the surgeons and general practitioners and patients alike, and now the question arises: How did the hospital operate before a resident physician was obtained?

PRINCE GEORGE'S COUNTY

SAMUEL J. M. SUGAR, M.D.

The monthly program of Prince George's County Medical Society for January 1952 will include:

1. A panel discussion of the Harrison Act and narcotic addiction. Members of the panel will be made up of members of the Treasury Department and two physicians who have had experience with drug addiction at Lexington, Kentucky.
2. Annual election of officers was held December 4, 1951. Results will be published in the next issue of the JOURNAL.
3. Results of the Diabetes Detection Drive were announced at a recent meeting. 482 urine tests were done. Of these, two were positive and six were questionable.

TALBOT COUNTY MEDICAL SOCIETY

The Easton Star—Democrat newspaper of Easton, Maryland, stated:

Talbot Medical Society Honors Dr. Wm. S. Seymour. Engraved silver tray commemorates 55 years of practice in County. "Presented to Dr. William S. Seymour July 18, 1951, by the Talbot County Medical Society in recognition of 55 years devoted to the practice of medicine." So reads the inscription on a silver tray presented to the man whom Dr. Shepherd Krech, president of the Talbot County Medical Society described as "the Society's most active member" at a testimonial dinner given in his honor in the Garden Room of Tidewater Inn on Wednesday evening.

"It is with great pleasure that we can tonight pay tribute to one of our colleagues who has served his community so loyally for 55 years," Dr. William D. Noble, chairman of the committee on arrangements, said in making the presentation. This engraved silver tray, he said, is a symbol of the "de-

votion and esteem" of the members of the medical profession in Talbot County.

It was on June 25, 1895 that Dr. Seymour first opened his office in Trappe, upon graduation from the University of Maryland. Three other physicians were already practicing in this village of some 300 persons, but the number is not as disproportionate

enough to warrant use of an automobile and even then, shell road surfaces were likely to cut tires so you had to continue on as best you could. He recalls his first automobile was a two cylinder Maxwell. "It was all right in summer, but I still had to rely on horse and buggy during winter months," he said.

When Dr. Seymour began practice there were no



as it may seem by modern standards. In those days the horse and buggy was the only mode of transportation. Roads were mostly "mud and dirt." So a doctor with a rural practice could see but very few patients each day. Today, it is not unusual for a physician to make 20 home calls in a single day.

Dr. Seymour says it was between 1915 and 1918 that the county began to get roads which were good

hospitals or nurses in the county. Deliveries had to be made by kerosene lamp, without assistance from anesthetist or nurse.

Dr. Guy Steele of Cambridge, who observed his 90th birthday on the 23 of June and who doesn't appear a day over 65, joined Dr. Seymour in reminiscing of the horse and buggy days of medicine in this section of the Shore.

Speakers were introduced by Dr. William T. Hammond who acted with Dr. Noble in arranging the testimonial.

The award is the first ever made by the Talbot County Medical Society for so long a tenure of service in the county and there is every indication Dr. Seymour will be on hand to mark further milestones as an active practitioner at suitable intervals for some time to come.

The Medical and Chirurgical Faculty extends its congratulations to Dr. Seymour.

WASHINGTON COUNTY MEDICAL SOCIETY HAGERSTOWN, MARYLAND

Beginning Sunday, September 30, the Washington County Medical Society will inaugurate a plan for the coverage of emergency cases in Hagerstown and Washington County.

While doctors here have always made a conscientious effort to take care of the emergency needs of the community, an occasional incident arises when it is difficult to obtain the family doctor or any doctor.

This unusual circumstance has usually occurred on a Thursday, Sunday or holiday.

While it is true that a majority of local physicians have no office hours in the afternoon and evening of these days, it is not true that many are away or out of town, a misconception that many people have had. They are, therefore, in many instances available for emergency work.

A substantial number on the Medical Society roster have volunteered to take care of the special emergency cases or sudden acute illness, when the family physician or his associate cannot be obtained on Thursday, Sunday, or a holiday.

Many cities of comparable size to Hagerstown or larger, have inaugurated similar systems for emergency coverage. By so doing, they have filled a need, which has given the public a better sense of security.

The Medical Society, naturally, does not want the system to be abused. So it has set up the procedure for the care of emergency cases and sudden acute illness.

It emphasizes that the family physician or his associate should be called first on a Sunday, Thursday, or holiday. If he cannot be obtained, the call should

be made to the Physicians Exchange, Hagerstown 2600, and a doctor will be secured.

Different doctors are serving their turn each week on a rotation basis.

The Medical Society reminded the public: First, call your own doctor. Do not call the Physicians Exchange, Hagerstown 2600, until you have made an effort to get your own doctor, or the doctor who is covering his work if he is engaged or away.—Courtesy of *The Daily Mail*, Friday, September 28, 1951.

THE BALTIMORE CITY MEDICAL SOCIETY

LOUIS A. M. KRAUSE, M.D.

The Baltimore City Medical Society, during the year 1951, has had a very successful year particularly from the point of view of their primary function and that is to promote the advance of medical science. I believe that one of the things that has contributed to the renewed enthusiasm at its meetings was the emphasis placed on a satisfying medical program.

The instructions to the Program Committee were: first, to furnish an attractive medical program; second, the absolute abandonment of refreshments at each meeting. It was felt that an adequate medical dish is the reason for the existence of the Society, and at no time should we resort to food as a means of maintaining or creating good attendance.

The Program Committee, under the able leadership of its Chairman, Dr. Wetherbee Fort, has accomplished outstanding results in the pursuit of the above policy, and the credit belongs entirely to this Committee.

I think it is apparent to all that our emphasis of such principles was entirely justified and I believe should be ever our inspiring motive.

MONTGOMERY COUNTY MEDICAL SOCIETY

KATHARINE A. CHAPMAN, M.D.

During the year 1951 the Montgomery County Medical Society has held meetings September to June on the third Tuesday of each month, each meeting preceded by a dinner served at Olney Inn, Olney, Maryland. At the annual meeting in March

the members of the Woman's Auxiliary were the guests of the Association.

Much time has been given during the year to the study of border-line medical practices such as naturopathy, podiatry and dianetics; also to revising the zoning ordinances so that doctors may have offices in Residential "C" areas (apartment houses) in which they do not reside.

To each member during the past year there has been sent a revised copy of the Constitution and

By-Laws and a copy of Medical Directory which was compiled for distribution to police and fire departments, school nurses and clinics, drug stores, rescue squads, and to new residents through the Welcome Wagon, Inc.

The present membership of the Society is 213 of which 162 are active, 50 associate and 1 honorary. Nine of the active members have been elected as life members. Eight members are in active military service.

SPECIAL ANNOUNCEMENT

The program of the February 15th meeting of the Baltimore City Medical Society is as follows:

8:30 P.M.

The Cause and Prevention of Homologous Serum Jaundice. J. GARROTT ALLEN, M.D., Associate Professor of Surgery, University of Chicago School of Medicine, Chicago, Illinois. (*By Invitation.*)

9:15 P.M.

Untoward Reactions from Blood Transfusions. C. LOCKARD CONLEY, M.D., Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

10:00 P.M.

Discussion period.

Library

THE LIBRARY—1930–1950

PAULINE DUFFIELD, *Librarian*

The library of the Medical and Chirurgical Faculty of the State of Maryland was organized in 1830. From its meager beginning and its wandering from home to home, it has survived to attain a proud place among the medical libraries of the United States.

The library has several endowments provided by members and their friends. They are the Finney, Stokes, Harlan, Baker, Barker, Ruhräh and Osler funds. These funds are set up to provide for the purchase of books and journals in the various special fields of interest of the donor. In 1892, the Faculty provided one half of its income for the library; in 1950, less than twenty per cent of the income was used for the support of the library; today, the library is striving to maintain the high standards set up by the physicians of this State.

In 1930, the library held its centennial, which was looked upon as one of the highlights of the Faculty. At this celebration, the late Marcia C. Noyes said, "But of all the activities of this old State Association—and they are varied—the library is the one of most permanent value. Its books are something concrete to show from generation to generation."

For the past twenty-one years, Dr. Andrew C. Gillis has served as Chairman of the Library Committee. During these years, he has given wise counseling to the library staff which has been greatly appreciated by all who have served under him. The position of Committee Chairman has been a most difficult one in view of the economic situation, the changes within the organization and World War II.

To mention a few of the changes that have taken place in the last twenty years would be to compare the size and growth of the library. In 1930, there were 37,481 volumes. Today, we have a total of 75,539 volumes and several thousand reprints which are available for use.

In 1934, a special tribute was paid to the memory of Dr. John Ruhräh, who had served as Chairman of the Library Committee and who also had held many positions in the Faculty. A memorial room was dedicated to house his collection of non-medical books. A proper and fitting bookplate was designed by the late Max Brödel. Dr. Ruhräh left his entire estate of over a hundred thousand dollars to eventually come to the library. The income is to be used to purchase books and journals in the fields of his special interests.

In 1936, the library was receiving 235 journals regularly. Ninety-one of these were gifts or exchanges with the transactions. In this same year, Dr. Stewart Paton donated to the library a very fine collection of eighteenth century rare books.

In 1941, Dr. Stewart Paton also gave the library a large collection of books on psychiatry. During this same year, the library also received several foreign journals from the William H. Welch estate to fill in our back sets.

A large collection of books was received from the Julius Friedenwald estate during the year of 1942.

A fine collection of great value in the field of medical history was given to the library by Dr. Walter R. Steiner in 1943. We are also future beneficiaries under his will.

In 1946, the death of Miss Marcia C. Noyes, who had served as librarian since 1896, was indeed a great loss to the library. The library had been her greatest interest for fifty years and the great collection she supervised is a memorial to her.

In 1948, through the efforts of Dr. Thomas S. Cullen and the Library Committee, the long-lost and, to our knowledge, the only copy of the 1835 Catalogue of the Library of the Medical and Chirurgical Faculty was returned to us from the Army Medical Library, where it had been a prized possession in their rare book collection before 1900.

The Eugene J. Leopold Collection, which was an outstanding collection of books on diabetes, was presented to the library by Mrs. Leopold.

In 1948, the rare book collection was enriched by the gifts of Drs. J. Albert Chatard and Ferdinand E. Chatard, IV. The gifts included *Liber Metricus de Pulsibus cum Commentarie Gentilis Fulginatis* by Aegidius Corboliensis (1484), *Incipit Excellentissimi Medici* by Petrus de Abano (1498) and *Aliquot Opuscula nunc Primum Venetorum Opera Inventa et Excusa* by Claudius Galen, (1550). We are indeed proud of these rare items.

The death of Dr. Harry Friedenwald in April, 1950, was a great loss to the Library and Finney Fund Committee on which he had served since 1896.

Through the courtesy of Dr. Beverley C. Comp-ton, the library secured two large display cases in which we can now display some of the rare items. At the present time, we have on loan a stamp collection of Dr. Margaret Ballard. Also on display are several items from the Steiner Collection.

Today, the library receives regularly 320 journals and has added approximately 417 books this year. The book lists have appeared in the monthly Bulletin.

In August 1950, Mrs. Nellie N. Cowles bequeathed to the library one thousand dollars, the income to be used to purchase books on neurology in the name of Dr. Lewellys F. Barker.

The library staff will at any time try to help the members in any way possible, compiling bibliographies, checking references or any of the many other details they may require. It is the desire of

the Library Committee and the library staff to serve the members, but to serve them we must know their needs. The library is only as far away as your telephone or mail box. We would like to remind the members outside of Baltimore City that the same service is offered to them if they will only make their needs known.

The library has been open three nights a week this year instead of the usual five. This has been, as far as we can tell, fairly satisfactory to everyone. However, if any member finds that the present hours are not to his convenience, we would appreciate his notifying the Chairman of the Library Committee.

The library has had great need of more space for several years. Earlier this year, it was necessary to move the material which was not indexed in medical literature to the basement. This allowed for the shelving of this year's journals and provided space for the next four years. However, the problem is far from being solved and the basement arrangement is entirely unsatisfactory.

The statistics show a gradual increase in the use of the library and its resources.

Circulation has increased slightly within the past three years. The figures show that 10,496 volumes were used in 1948, 11,497 in 1949, and 11,054 in 1950.

The library should be looked upon by all members with great satisfaction. It held and strengthened the Society for many years. Your choicest treasures are housed in the library, the old and new discoveries of science, the records of the past and the present are all gathered together. It is your library.

A FEW OF THE RECENT PUBLICATIONS BY FACULTY MEMBERS

Abeshouse, B. S.

Aneurysm of the renal artery: report of two cases and review of the literature. Urologic and Cutaneous Rev. 55: 451-463, Aug., 1951.

Diverticula of anterior urethra in the male: a report of four cases and a review of the literature. Urologic and Cutaneous Rev. 55: 690-707, Nov., 1951.

and Scherlis, I., Golden, M. and Rubin, M.

Aortography and renal arteriography following percutaneous retrograde catheterization of the femoral artery and aorta. Urologic and Cutaneous Rev. 55: 517-528, Sept., 1951.

Blair, E. and Brantigan, O. C.

Perforation of gastrojejunal ulcer following subtotal gastric resection for duodenal ulcer. Case report. Bull. of the School of Med., Univ. of Md. 36: 133-136, July, 1951.

- Broyles, E. N.
The diagnosis and treatment of early malignant disease of the larynx. *Southern M. Jr.* 44: 692, Aug., 1951.
- Brunst, V. V., Barnett, D. J., and Figge, F. H. J.
Reaction of tissues of amphibians after local roentgen irradiation. *Amer. Jr. Roentgenol.* 66: 420-434, Sept., 1951.
- Bubert, H. M.
Penicillin in bronchial asthma. *Bull. of the School of Med., Univ. of Md.*, 36: 115-118, July, 1951.
- Curtis, R. M., Brewer, J. H. and Rose, I. A. (Jr.)
New technique for local treatment of burns. *J. A. M. A.* 147: 741-743, Oct. 20, 1951.
- Decker, H. C., McDowell, F. W. and Trimble, I. R.
Pheochromocytoma, case report with discussion of differential diagnosis and surgical treatment. *J. A. M. A.* 147: 642-645, Oct. 13, 1951.
- Feldman, M. and Weinburg, T.
Healing of peptic ulcer. *Amer. Jr. Dig. Dis.* 18: 295-296, Oct., 1951.
- Fitzpatrick, V. DeP., Hunter, R. E. and Brambel, C. E.
The use of multiple intestinal absorbents as an adjunct in the management of nausea and vomiting in pregnancy. *Amer. Jr. Dig. Dis.* 18: 340-342, Sept., 1951.
- Gann, E. and Hoffman, E.
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EUROPEAN MEETINGS 1952

- July 8 to 11, British Congress of Obstetrics and Gynecology, Leeds, England.
July 8 to 13, Commonwealth and Empire Health and Tuberculosis Conference, London, England.
September 8 to 13, International Congress on Neuropathology, Rome, Italy.
July 14 to 19, International Congress of Physical Medicine, London, England.
July 19 to 25, International Congress of Radiology, Copenhagen, Denmark.

Board of Medical Examiners

THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF MARYLAND

Faculty Annex, 1215 Cathedral Street

LEWIS P. GUNDRY, M.D.

Secretary

In order to acquaint the membership with the responsibilities and activities of the Board of Medical Examiners, it is proposed to submit a report at infrequent intervals. The following was received from Lewis P. Gundry, M.D., Secretary of the Board:

The Medical and Chirurgical Faculty or Medical Society of the State of Maryland was established by an act of the Legislature in the year 1799. This Act also provided that there be appointed a Board of Examiners consisting of twelve persons—seven from the Western and five from the Eastern Shore. As presently constituted, the BOARD was established by an act of the Legislature in 1892. It is known as the Board of Medical Examiners of the State of Maryland and is composed of eight members. Board members are elected by the Medical and Chirurgical Faculty at their annual meeting in April; two being elected every year for a term of four years. Since each physician on the Board is selected and elected by the Medical Society he is not a political appointee and is in no way hampered by political pressures.

To conduct their official business the Board holds meetings at regular intervals. At the annual meeting in June a president, vice-president and a secretary-treasurer are elected for a term of one year. These three members constitute the executive committee of the Board. One of the most important functions

of the Board is to give written examinations to eligible candidates. Each member of the Board is designated to give and mark examinations in one subject. At present, examinations are given in anatomy, physiology, chemistry, surgery, practice of medicine, therapeutics and pharmacology, obstetrics, and pathology.

It is the responsibility of the Board under the Medical Practice Act to issue licenses to those who qualify after written examination and to those who present proper credentials for license by reciprocity from another state, or endorsement of a National Board certificate. The Board may revoke any license which it has issued for a number of causes which are listed in the Medical Practice Act. Statistics relating to licensure in this and other states are published each year in the State Board number of the Journal of the American Medical Association.

The Board of Medical Examiners of the State of Maryland is a member of the Federation of State Medical Boards of the United States. The Board sends one or more delegates each year to the Annual Congress on Medical Education and Licensure held in Chicago by the Federation of State Board and the Council on Medical Education and Hospitals of the American Medical Association. At this meeting problems of mutual interest concerning licensure and medical education are discussed.

Health Departments

GREETINGS FROM THE STATE DEPARTMENT OF HEALTH

The State Department of Health extends its cordial welcome to this new publication of the Faculty. The MARYLAND STATE MEDICAL JOURNAL should serve a most useful purpose in keeping members informed of current medical happenings in the State and in making possible complete coordination between the work of the medical profession and that of those public agencies whose functions involve medical considerations.

It is the purpose of the State Department of Health to make use of this new organ to familiarize the members of the profession with changes in its procedure and with current happenings in the field of public health.

It is our earnest hope that the members of the Medical and Chirurgical Faculty will use its pages to express their opinions about public medical questions and to register any criticisms or complaints that they may have of our service.



Director

BALTIMORE CITY HEALTH DEPARTMENT

It is with much satisfaction that the Baltimore City Health Department sends this greeting to the Medical and Chirurgical Faculty of Maryland on the occasion of the inauguration of the MARYLAND STATE MEDICAL JOURNAL. The Faculty and the Department have been teammates in working for the best interests of the people of Baltimore for many decades, for both had their start in the 1790's and each has included members of the other in its ranks from the beginning.

In the November, 1931 issue of *Baltimore Health*

News, after referring to the sterling work of Dr. C. Hampson Jones, then Commissioner of Health of Baltimore, and of the martyr city bacteriologist, Dr. William Royal Stokes, and to the changes and developments in modern public health, I wrote

Leadership in health promotion is the function of a health department. It should organize a far-reaching program. No health department can do its job along modern lines, however, without the active support of the medical profession. We need this support and expect to receive it. Such work as the eradication of diphtheria, the reduction of the venereal diseases and the adequate care of expectant mothers and of young children must rest largely in the hands of the practicing physicians. We can do much as a health department to teach the public to seek such "keep-well" services.

Only with the united backing of the physicians and the individual citizens can the Baltimore Health Department accomplish its true purpose as the standard-bearer of better city health.

During the past twenty years many changes have come into the public health picture in Baltimore and elsewhere. It is the hope of the City Health Department that during these years it has merited the good will and backing of the many physicians who make up our profession in the city. Very real efforts have been made to bring about this spirit of teamwork and they will continue to be made.

Together, and hand in hand with our sister Department which serves the counties of Maryland, we may go forward confidently to face the health and medical and social challenges of today and tomorrow; such challenges as a better organization of the medical care services for all the people, geriatrics and its many complex implications, improved housing with a resulting better health and life for the less privileged, the teen-age use of narcotics, fluoridation of the city water supply and the eventual control of the overpollution of the city's atmosphere.



Commissioner of Health

Hospital News

HOSPITAL AND HEALTH FACILITY CONSTRUCTION UNDER THE MARYLAND HOSPITAL SURVEY AND PLAN

HERBERT G. FRITZ

Chief, Division of Hospital Services State Department of Health

Hospital and Public Health facility construction in Maryland under the Federal Hospital Survey and Construction Act for the first five years (1948-1952) of the program will amount to \$17,126,471.00 when projects now in progress or approved for construction are completed. This includes 25 projects. The Federal share of the above cost is \$5,197,836.06

The 25 projects include the following:

- (1) New Garrett County Memorial Hospital at Oakland, Garrett County.
- (2) New Calvert County Hospital, Prince Frederick, Calvert County, replacing old hospital which was unacceptable.
- (3) Addition to the Washington County Hospital at Hagerstown, Washington County.
- (4) Addition to the University of Maryland Hospital including a psychiatric unit and general hospital beds in Baltimore.
- (5) Addition to the Prince George's General Hospital at Cheverly, Prince George's County.
- (6) Addition to the Frederick Memorial Hospital at Frederick, Frederick County.
- (7) Addition to the Peninsula General Hospital at Salisbury, Wicomico County.
- (8) Addition to the Memorial Hospital at Cumberland, Allegany County.
- (9) New tuberculosis hospital for the Associated Jewish Charities of Baltimore.
- (10) New addition to the tuberculosis unit of the Baltimore City Hospitals, Baltimore.
- (11) New Christ Child Convalescent Hospital (chronic disease hospital for children), at Rockville, Montgomery County, replacing an unacceptable facility.
- (12) Remodeling the State Bacteriology Laboratory Building in Baltimore.
- (13) New Health and Welfare Building at Annapolis, Anne Arundel County.
- (14) New Auxiliary Health Center at Havre de Grace, Harford County.
- (15) New Health Center at Westminster, Carroll County.
- (16) Equipment for the Southern Health District Building at Baltimore.
- (17) New Health Center at Denton, Caroline County.
- (18) New Health Center at Leonardtown, St. Mary's County.
- (19) New boiler plant at Annapolis Emergency Hospital Association, Annapolis, Anne Arundel County, where a large wing will be added to the hospital.
- (20) Addition to the Kent & Queen Anne Hospital at Chestertown, Kent County.
- (21) Addition to the Easton Memorial Hospital at Easton, Talbot County.
- (22) Addition to the Annapolis Emergency Hospital at Annapolis, Anne Arundel County.
- (23) New power plant for the Franklin Square Hospital in Baltimore City, where a large addition is planned.
- (24) New Health Center at Chestertown, Kent County.
- (25) Equipment for the Southeastern Health District Building in Baltimore.

The program operates under the Maryland Hospital Survey and Plan. The original survey was made under the Maryland State Planning Commission.

Applications may be accepted only from governmental bodies or non-profit corporations. Projects are approved in accordance with a priority schedule which is a part of the Maryland Hospital Survey and Plan. This plan and the priority schedule are revised annually to account for changes such as new construction, population shifts and utilization of existing facilities. Emphasis is placed on locating new or additional facilities at points of greatest need, the need being determined by the relationship of existing facilities to the determined need and current utilization of existing facilities.

Priority between various categories of facilities such as tuberculosis, chronic disease, mental and general hospitals is based on the degree to which the need is met in each category. As a result of the application of these factors construction of general hospital facilities has been largely in rural areas. At the same time there has been construction in each of the categories. If the program is continued on this basis, ultimately, there will be a balance between the several categories, the limiting factor being the availability of matching funds. Ten per cent of the Federal allotment is made available for public health center construction.

Considerable use is made of the State Plan by groups considering hospital construction whether or not they intend to apply for Federal assistance. It is used as a guide in determining the need for a hospital construction program in their community and the size to which it should be planned.

Since priority is granted on the basis of percentage of met need and utilization of existing facilities it is extremely unlikely that a community or group having funds available for the construction of a hospital will be encouraged or assisted financially with the project if the need is not apparent and efficient utilization is not being made of the existing facilities in the community. The only exception to this would come about if the existing facility is unsafe and not considered acceptable.

The program has brought into existence consulting services which had not previously been available to sponsors of hospital projects or the architects whom they employ. Technical consulting services are available at the State level and through the State agency at the Federal level. The services of personnel of the State Department of Health, Division of Hospital Services, available for consultation includes an archi-

tectural engineer and an architect, a hospital administrator, a consultant dietitian, nurses with degrees and broad experience in hospital administration and public health services. Their services are available for preliminary discussions and throughout the development, construction and equipping of the project.

The following account of the procedure of a project illustrates the working of the program, including the use of the services available:

The Board of a hospital, either existing or proposed, will usually start the construction program by deciding to investigate the need for new or additional facilities in the community or area. The first resource is the State Plan, copies of which are available to them. The Plan shows the number of hospital beds available, the percentage of occupancy and the priority status of the area. With this information as a point of departure a study of local conditions can be initiated.

Sponsors are advised to employ a hospital consultant to assist with a detailed study of the community needs. When such consultant is employed, the services and files of the Division of Hospital Services are made available to him.

As soon as an architect is commissioned for the project he is advised of the availability of services in the Division of Hospital Services. He is supplied with materials prepared at both the State and Federal levels. The facility must comply with minimum standards established at the Federal and State levels, however, the architect is not otherwise bound insofar as esthetics and design are concerned.

When the size of the facility needed is determined the architect as a rule will prepare schematic, single line floor plans. These may be submitted to the Division of Hospital Services for review, either before or after review by the sponsoring group. The drawings are reviewed for inclusiveness of facilities, functional layout, space assignment and compliance with minimum standards. After conferences intended to arrive at concurrence between the Division of Hospital Services, the architect and the sponsors, revised schematic drawings are prepared by the architect incorporating the changes agreed upon. These revised schematic drawings are then submitted to the U. S. Public Health Services, Division of Hospital Facilities, for review and approval. Should the Federal reviewing agency make recommendations

these are transmitted to the architect and the Board. When Federal approval has been obtained, the architect and sponsors are notified.

The architect then proceeds with preliminary drawings showing more detail, including built-in equipment. These drawings are processed in the same manner as the schematic drawings. When necessary approvals have been obtained he proceeds with the development of working or contract drawings and specifications. These are subject to the same reviews and approvals.

This procedure insures the inclusion of necessary facilities, proper functional relationship of departments and proper space allotments.

Contracts must be on a competitive, lump sum basis. Bidders must give assurance that they will pay prevailing wages approved by the U. S. Department of Labor.

During construction inspections are made by State and Federal representatives to ascertain that the project is being built in conformity with specifications.

Upon completion and settlement of obligations Federal participation and authority ceases. The only continuing Federal right is that of recovery if the facility ceases to be used as a public or non-profit hospital within a period of 20 years.

FINANCES

The current rate of Federal participation is $33\frac{1}{3}\%$. This has fluctuated from $33\frac{1}{3}\%$ to 44% and back to $33\frac{1}{3}\%$ as the amount of Federal funds have been changed by Congress. Federal funds are applicable

to construction and equipment costs on hospital projects. On projects for public health facilities the cost of the site is included.

Sponsors are required to have in cash or liquid assets one-third of their share of the estimated cost at the time of filing the first part of their application. Before the project is finally approved for contract, the full amount of the sponsor's share must be available. Borrowed funds are limited to one-third of the sponsor's share. Federal funds are paid to the sponsors on the basis of physical completion.

Sponsors are required to estimate the amount of deficit which might be expected during the first two years of operation and show the source of funds for underwriting the calculated deficit.

These regulations give assurance that the project will be completed and deficits for the first two years of operation will be met.

The program was originally established for a five year period ending in 1951 but Congress has extended it to 1956.

The amount of construction under the program is limited by the amount of Federal funds available. Construction within this limitation cannot provide sufficient hospital facilities to meet the need for additional facilities in Maryland. If the need is to be met much construction will have to proceed without benefit of Federal funds.

The program has apparently met with general approval since all funds available have been used. It is felt that under the program hospital construction has proceeded in an orderly manner at points of determined need.

PRESENT STATUS OF STUDY OF PREMATURES

PAUL HARPER, M.D.

In the August issue of the News Letter of the Medical and Chirurgical Faculty of the State of Maryland appeared an announcement that the Faculty had endorsed a statewide Study of Prematures. This is an important study being undertaken by the Division of Maternal and Child Health of the Johns Hopkins University. The full cooperation of all physicians in the State is urged. By the time this article

appears in print a pilot study should have been completed and the study itself should be under way in all hospitals in the State with maternity services. Also by this time most physicians in the state should have received a letter explaining various features of the study.

The need for the study arises from the fact that prematurity is steadily becoming of relatively greater

importance as a cause of infant death. This is not because of an increase in prematurity but because of the rapid decline of deaths due to infection. The study has two aims, first, to evaluate the hospital care rendered prematures in terms of survival, and, second, to determine how many of those prematures who do survive develop normally and in what ways the other survivors are handicapped. For the purposes of the study a premature infant is being defined as any live born infant whose weight at birth is 2500 grams (5 pounds, 8 ounces) or less; and all such infants born in Maryland in 1952 are to be included. Although this means some 3000 prematures, the average will be only about two per physician.

The evaluation of hospital care will be undertaken by means of comparing the neonatal mortality of premature's cared for in different groups of hospitals. A survey of the arrangements and practices for the care of prematures in the hospitals is now about half complete. In addition, all hospitals are co-operating in furnishing information about the prematures on such items as prenatal care, complications of pregnancy, data about labor and delivery and the care of the premature after birth. It is possible that this study will suggest that more attention should be given to the prevention of prematurity by such measures as early hospitalization of mothers with complications, rather than putting the major

emphasis on the treating of prematures after they arrive.

The follow-up of those prematures who survive their first month will also be conducted on a state-wide basis. All prematures born in Maryland to residents of Maryland will be followed throughout their first year of life. The object will be to obtain information concerning the developmental level of each premature at several points during his first year.

In addition to this, there will be in Baltimore a relatively small group of prematures and a comparable group of full-term infants serving as controls who will be given a Gesell Developmental Examination at forty weeks of age. Although the Gesell Developmental Examination is to be done routinely only on the limited group in Baltimore, such an examination is being offered as a matter of courtesy to all physicians throughout the State for any of their prematures about which they may be particularly concerned. Such examinations will be for diagnosis only. A report of findings will be furnished to the referring physicians and the infant's mother will be returned to him for all advice. Present plans also include following this limited group in Baltimore beyond their first year, possibly well into their school years.

The Study Staff plans to provide information concerning the Study from time to time so that the physician will be kept up to date on its progress

Insurance

BLUE SHIELD PROGRESSES

Just a year ago, November 1, 1950, Dr. Hugh J. Jewett, President of the Board of Trustees of Maryland Medical Service, Inc., presented Maryland's first Blue Shield membership certificate to Miss Ann Charshee of Parke, Davis & Company's Baltimore office. Only six days later the first patient, Miss Dorlene Shantz of Hagerstown, went to a hospital.

Today there are more than 55,000 members of the new Plan.

In addition, slightly over 100,000 Marylanders are now protected (since September 1st) under a special contract with the Bethlehem Steel Company which provides surgical benefits only. National Blue Shield contracts with various steel companies now protect more than 1,500,000 persons.

During the first nine months of 1951, more than 4,000 persons received Blue Shield benefits, totaling over \$200,000.

Meanwhile, the list of Participating Physicians has grown from the original 1,400 to more than 1,550 and new Participating Agreements are being received each week.

Through the year, members of the Plan's Board of Trustees have held their regular monthly meetings as well as several special meetings. Members of this Board, headed by Dr. Jewett are: Dr. Warde B.

Allan, Vice-President; Mr. Donald H. Sherwood, Secretary; Mr. Robert O. Bonnell, Treasurer; Mr. Hilary W. Gans, Dr. Frank F. Lusby, Dr. J. Morris Reese, Dr. Benjamin S. Rich, Dr. Alexander J. Schaffer, Dr. I. Ridgeway Trimble, Dr. Henry F. Ullrich and Mr. Harvey H. Weiss.

The Medical Relations Committee and the Reference and Appeals Committee, the members of which are appointed by the Council of the Medical and Chirurgical Faculty of the State of Maryland, have been active in carrying out their functions.

The Medical Relations Committee consists of the eight medical members of the Board of Trustees in addition to Dr. John W. Parsons, Dr. S. Edwin Muller and Dr. J. H. Mason Knox, III.

The Reference and Appeals Committee consists of Dr. Parsons, Dr. Knox and Dr. Muller, also Dr. Thurston R. Adams, Dr. John B. DeHoff, Dr. Lester T. Chance, Dr. Donald Hooker, Dr. E. T. Lisansky and Dr. E. Roderick Shipley.

The total national Blue Shield membership now totals more than 21 million persons. As of June 30, 1951, the Michigan Blue Shield Plan led all the others with more than 2,280,000 subscribers followed by New York with an enrollment of over 2,200,000.

EDITORIAL BOARD ANNOUNCEMENT

The following counties have submitted candidates for nomination to the Editorial Board: Allegany-Garrett, Cecil, St. Mary's and Washington. Every County Medical Society has been requested to submit suggestions for these positions on the Board.

The Auxiliaries

Woman's Auxiliary to the Medical and Chirurgical Faculty

NEWS OF COMPONENT AUXILIARIES

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

Mrs. George Urban, President of the BALTIMORE COUNTY AUXILIARY, reports a busy year. Tea was served on two occasions, by Auxiliary members, for the doctors attending lectures on Atomic Defense. In March, a benefit dance, held to finance Maryland's first Nursing Scholarship, was a great success. The recipient of the scholarship, Miss Patricia Leffell, of White Hall, Maryland, is now in training at the University Hospital. Baltimore County plans to make this a yearly project.

Mrs. Urban also reports the work done at the Timonium Fair an outstanding success. During the week of the Fair, over 14,000 pieces of literature were distributed; in addition, the Auxiliary sponsored a health booth. Three films were shown, one on narcotics addiction, another on the use of animals in medical research and a third showing the disadvantages of Socialized Medicine. Baltimore County is an inspiration to us all.

BALTIMORE CITY AUXILIARY has an important project for the year, namely, "To Educate Ourselves On Health Problems." Mrs. H. Hanford Hopkins, President of the Auxiliary, reports that at the October meeting, Dr. L. B. Davis gave an interesting talk on "Drug Addiction in the Public Schools." In December, Dr. John L. Krantz addressed the members—his subject, "Physicians, Potions, People and their Purses." He discussed the improper use of antibiotics, diets, drugs and patent medicines.

Mrs. James P. Kerr, President of MONTGOMERY COUNTY AUXILIARY, sends word that at their November meeting, Dr. Welte of Rock Hall, spoke on the subject of Tuberculosis. They, also, are planning to start a scholarship for the nurses and in addition are working to interest the schools in an Essay Contest on the outstanding success of American Medicine under our system of free competition.

PRINCE GEORGE'S COUNTY AUXILIARY

Mrs. Jack Sugar, President, is a third group sponsoring a nurse's scholarship for a three year period. During October the members of this Auxiliary donated blood to the Red Cross. Mrs. Sugar also reports a contribution of one hundred dollars to the Doctors Library, of the Prince George's General Hospital. Last year a donation of one hundred dollars was made to the County Health Drive.

Mrs. John H. Beachley, President of WASHINGTON COUNTY AUXILIARY, tells us that members have been most cooperative and generous in giving their time to help with the Tuberculosis Stamp Sale, the March of Dimes and the Red Cross Drive. They assumed the entire responsibility of staffing a Cancer Booth in a downtown store during the month of April, either serving personally or supplying a worker. Also, they have shipped to New York, for use overseas, a seventy-five pound box of drugs, a small quantity of supplies and medical instruments, A.M.A. Journals, as well as packs of transcripts of Medical Research Literature.

This month we have no report from Cecil, Dorchester and Frederick Counties, but hope to give you news of them in the next issue.

THE CHICAGO CONFERENCE

A worthwhile trip to Chicago was made by our President, Mrs. George H. Yeager, and the President-elect, Mrs. Charles H. Williams, to represent us at the November Conference of the Woman's Auxiliary to the A.M.A. They returned with a number of new ideas to further our program on Public Medical Education and Nurse Recruitment. For example, to increase interest in Nurse Recruitment, there is an excellent sound film, called "Girls in White," which can be obtained from the American Hospital Association, 18 East Division Street, Chicago 10, Illinois.

To combat apathy concerning Civil Defense in

Maryland, which is one of four target areas in the United States, the various Auxiliaries to the Medical Societies can do an important job. We are asked to urge immediate procurement of individual identification tags and blood typing in our communities.

Working details of conference suggestions will be relayed to each County Auxiliary through the appropriate state committee chairman.

OUR CONTRIBUTION TO THE CONFERENCE

Largely due to the success of Maryland's work last year for the use of animals in research, the National Auxiliary is planning to make Medical Research a permanent part of its regular program. Our Maryland Auxiliary can be proud of the fact that articles describing our work have appeared in the "Bulletins" of both the Maryland and National Medical Research Societies.

LEGISLATIVE LIGHTS

Did you know that there is a proposed 23rd Amendment to the Constitution—a bill which would limit government competition with private professions and businesses?

Also, there is a House joint resolution (No. 268) limiting income tax to not more than 25% of anyone's income! If you approve these measures, why not support them?

Did you know that women's organizations and women's magazines are propaganda targets for 1952? Let us weigh the truth of what we read and hear. Our loyalty should be to the U. S. principle of the rights of the individual, not to any party, administration, or government department.

Did you know that, in a survey of several hundred consecutive admissions to a Veteran's Hospital, 90% were admitted for illnesses which were not service connected? Sixty-five (65) per cent of the total number of patients admitted willingly took

the "Pauper's Oath," in order to enter! How many of these could well afford to be treated at their own expense?

The sum of \$10,000 was awarded to Senator James E. Murray, Democrat of Montana, by the C.I.O. This award was turned over to the "Committee for the Nation's Health," for use in promoting National Compulsory Health Insurance, in the U. S. A.

Colorado has the honor of *being the first* of the Woman's State Auxiliaries to contribute to the American Medical Education Foundation (the A.M.A.'s private fund for Medical Education).

AMERICANISM QUIZ

"How do we play into the hands of communists when we defend Americans in groups, according to color, minority or economic interests, rather than as individual citizens?"

For the answer read "The Key to Peace," by Clarence Manion. Heritage Foundation Inc., 75 East Wacker Drive, Chicago, Illinois. \$2.00. The Public Libraries.

"Would you let your husband stop the practice of medicine and sacrifice your security, to run for Congress and work for better government? (You let them take your son for Korea!)" Excerpt from a speech at the Chicago Conference, made by Doctor Judd, Congressman from Minnesota, who did give up his medical practice to work for the U. S. A.

"Why have educators only themselves to blame if the germ of cynical worldliness and moral delinquency has invaded the college campus?" Dr. Gibson in his inaugural address at Washington College, Chestertown, Maryland, gives the answer. His opinion that educators today are yielding to outside pressures and to the encroachment of the Federal Government is supported by Dr. Felix Worley, former President of Haverford College.

Ancillary News

PHARMACY SECTION

L. M. KANTNER, *Phar.D.*

Director Drug Control, State Department of Health and Secretary of the Maryland Board of Pharmacy

The Medical and Chirurgical Faculty is to be congratulated upon the inauguration of a monthly journal. I feel assured this journal will have enthusiastic support, and will prove a most valuable publication to the practicing physician. It is indeed a privilege to be afforded an opportunity to contribute to this, the first edition.

This would seem an appropriate time to briefly discuss the recently enacted amendment to the Federal Food, Drug, and Cosmetic Act, which affects the prescribing and dispensing of what may be termed "Dangerous Drugs."

In 1948, the Commissioner of the Food and Drug Administration, in an interpretation of the law, held that *any* prescription once filled could not be legally refilled, and compared a prescription once filled to a "canceled check."

This interpretation caused interested groups to protest such a ruling, with the final outcome of the presentation and passage by the Congress of an amendment to the Federal Food, Drug, and Cosmetic Act clarifying this controversial question.

The continuous development of new drugs, together with a better understanding of the pharmacological action of many of the older drugs, makes necessary legal restrictions to surround the administration and dispensing of these products. That is what this amendment has endeavored to do as well as to clarify a confused condition.

Drugs intended for use by man are now divided into two classes: namely, those that can only be

dispensed on prescription, whose label must include: "Caution: Federal law prohibits dispensing without prescription."

Prescriptions for these drugs can be ordered on written prescriptions or given orally by the physician. In the latter case, the pharmacist must immediately reduce the order to writing and file. Such prescriptions cannot be refilled except by authorization of the physician, either on the original prescription or by oral instructions. Physicians' clerical or professional assistants may orally convey the physician's instructions to refill such prescriptions. However, the patient cannot orally transmit such instructions.

In the second class are drugs that can be sold without prescriptions. Prescriptions for this class of drugs can be refilled without the prescriber's authorization.

Physicians can save themselves a great deal of annoyance if they form the habit of indicating on their written prescriptions that they may or may not be refilled by using such abbreviations as N.R., Refill 1-2-3-4 times, or Refill P.R.N. When only the term "Refill" is used on prescriptions, it will most likely be held to refill once and once only.

This amendment should not be confused with the State Barbiturate Act, which provides that prescriptions for straight barbiturates, such as Nembutal, Seconal, Barbital, etc., must be written by the physician. The Maryland law does not provide for oral prescriptions for these drugs. However, physicians may authorize them to be refilled on the written prescription.

Letters to the Editor

November 1, 1951

Dr. George H. Yeager, Secretary
The Medical and Chirurgical Faculty
1211 Cathedral Street
Baltimore 1, Maryland

Dear Dr. Yeager:

I have conferred with Mrs. H. Hanford Hopkins, President of the Woman's Auxiliary to the Baltimore City Medical Society, and with our Program Chairman regarding preparation of our meeting notices to appear in the new Journal in January 1952.

The Woman's Auxiliary would like to congratulate the Society on the new undertaking and affirm our fullest cooperation.

Most sincerely,

Louise F. Johnson

(Mrs. Marius P. Johnson)

Corresponding Secretary

Woman's Auxiliary to the

Baltimore City Medical Society.

ANNUAL MEETING FEATURE

April 29 and 30, 1952

The Woman's Auxiliary to the Medical and Chirurgical Faculty will sponsor, under the Chairmanship of Mrs. Beverley C. Compton, a Creative Arts Show. In 1951 this was an outstanding event of the Annual Meeting. The members, their wives and children, are urged to exhibit. Send your requests to enter the 1952 Show to Mrs. Compton at the Faculty Building, 1211 Cathedral Street.

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

 VOLUME 1

February, 1952

NUMBER 2

COMMENTS

GEORGE H. YEAGER, M.D.

Editor and Secretary

"Unimportant of course, I meant," the King hastily said, and went on to himself in an undertone, "important, unimportant, important" as if he were trying which word sounded best.—Alice in Wonderland, Lewis Carroll.

The purposes of this Faculty shall be to federate and bring into one compact organization the medical profession of the State of Maryland; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to foster friendly intercourse among physicians; and to enlighten and direct public opinion so that the profession shall become more useful in the prevention and cure of disease; in prolonging and adding comfort to life, and in promoting a satisfactory distribution of medical care to the citizens of Maryland.

Thus, in Article II of the Constitution and By-Laws of the Medical and Chirurgical Faculty of the State of Maryland the purposes of the Society are defined. Do you help with its purpose? Do you participate in its functions? This organization has been a potent factor in the professional and civic life of Maryland. It can become much more effective if each member will demonstrate at least an active interest in his component society. Vigorous component societies will mean a thriving State Society with expanding interests.

Establishment of the Maryland State Medical Journal has resulted in both praise and criticism. Valuable suggestions have been contained in some of the criticisms. In addition to the other purposes of the Journal, let us use it as a "sounding board" not for the "staff" nor the officers, but for the individual membership. Long has there been need of

such! In addition to containing news, and scientific information, let it serve as a medium for the exchange of ideas. Utilize the Journal to further enhance the purposes of this Society. Thereby, it can serve as a medium of physical access and overcome some of the previous geographical limitations of this Society.

FREDERICK COUNTY ACHIEVES¹

Under Frederick County Medical Society News the following modest announcement appears: "A unique organization has sprung up in Frederick County known as Hospital Aid, Inc. It has been established and incorporated by civic minded professional, industrial, agricultural and commercial individuals. The aim of Hospital Aid, Inc., is to help directly those confronted with illness or accident which necessitates hospitalization when insufficient funds are available to meet unexpected hospital bills. Hospital Aid, Inc., after proper investigation of requests for assistance, will pay the hospital bill. The loan can be repaid without interest, at a rate convenient for the borrower, as little as a dollar a week." Additional details may be noted in the original announcement.

Such an organization reveals a remarkable concept of *civic pride* and *local responsibility*. Expansion, and integration of this idea to other communities on a nationwide scale, plus existent and contemplated prepayment insurance plans should further weaken the arguments of the "Social Planners" for Nationalization of the Medical Profession.

¹ The development of this movement will be brought to the attention of the American Medical Association.

Reports

COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS

BEVERLEY C. COMPTON, M.D., *Chairman*

The Annual Meeting of the Medical and Chirurgical Faculty will again be held in our building on Monday, Tuesday and Wednesday, April 28, 29 and 30, 1952.

Monday will be devoted to business sessions and Tuesday, April 29, and Wednesday, April 30, will be primarily scientific sessions with some business meetings interspersed.

On Tuesday, all features should be of interest to the Component Medical Societies. From 9:00 A.M. to 10:00 A.M., movies will be shown which have been produced in our own local institutions. Following this, from 10:00 A.M. to 11:00 A.M., there will be a Clinical Pathological Conference by the group from the University of Maryland School of Medicine. This will be followed with talks entitled, "You and Your A. M. A.," by speakers furnished by the American Medical Association. The office of the Medical and Chirurgical Faculty has been besieged with questions regarding the activities of the American Medical Association. This part of the program is an attempt to answer these queries. Following the presentation by the American Medical Association delegates, there will be a one-half hour period devoted to questions and answers.

On Tuesday afternoon, from 2:00 P.M. to 4:00 P.M., the session will consist of a Panel Discussion on the "Contraindications to ACTH and Cortisone," with Dr. Warde B. Allan, moderator, and Dr. A. McGehee Harvey and Dr. John C. Krantz, Jr., speakers.

On Tuesday evening we have the Presidential address by Dr. Alan M. Chesney, followed by Dr.

C. P. Rhoads, Director, Memorial Center for Cancer and Allied Diseases and Professor of Pathology, Cornell University Medical College, who will give a talk on "Recent Developments in Cancer Research."

Wednesday, April 30th, we will again have our locally produced movies from 9:00 A.M. to 10:00 A.M. From 10:00 A.M. to 11:00 A.M., a Clinical Pathological Conference will be presented by The Johns Hopkins University School of Medicine group. From 11:00 A.M. to 11:30 A.M., Sir Allen Daley, Medical Officer of Health of London County Council, will discuss "The Relative Position of the Specialist, the General Practitioner and the Public Health Officer in Britain." From 11:30 A.M. to 12:30 P.M., we are fortunate in securing Dr. Osler A. Abbott, of the Emory University School of Medicine, who will talk on "The Recent Advances in Surgery of the Autonomic Nervous System."

The Wednesday afternoon session, from 2:00 P.M. to 4:00 P.M., will be taken by the Chest group, with a Panel Discussion.

The speaker for Wednesday evening, at this writing, has not been secured. Preceding the Wednesday evening address, a delectable buffet supper will be served.

The Committee on Scientific Work and Arrangements urges the members to set aside this time for the purpose of attending the Annual Meeting of their State Medical Society. Attendance in the past by our members, as compared to other state societies, has always been very poor. The above program should stimulate better attendance.

"The Council of the Medical and Chirurgical Faculty is in full support of the Board of Medical Examiners in their action in taking the licenses away from physicians convicted in Court of income tax evasion, and further desires that this support by the Council be publicized in the Maryland State Medical Journal."

COMMITTEE FOR THE STUDY OF CERTAIN PHASES OF MEDICAL ECONOMICS*

WALDO B. MOYERS, M.D., *Chairman*

PRIVATE OR GOVERNMENT CONTROL OF THE PRACTICE OF MEDICINE

Which do you want? Are you willing to work and fight for private control of the medical profession? If so, it is time to start or we will be behind the proverbial "eight ball" before we realize it. The economic side of medicine is basic in its control. Once a doctor is not able to make a decent living for himself and family he will start looking for some other method. This is our vulnerable spot and we are doing very little about it.

Let's take a look at the picture. A student finishing high school, if he wishes to become a doctor, enters a period of training from eight to thirteen years. At the end of this period when he starts to practice he has an investment of at least thirty-five thousand dollars (see report). He now must build up a practice and is eight to thirteen years behind the individual who started in business after high school. His investment is considered a capital asset but there is no way to deduct this as other business men do. This has no capital value to anyone but the doctor and is completely wiped out at death or disability. Still the doctor pays income tax the same as the man who started earning at 18. The doctor also has to keep up a higher standard of living, and to contribute freely to all community projects, and is always charged top price for any work done.

The following report by Frank G. Dickinson, Ph. D., Director of the Bureau of Medical Economics Research A.M.A., gives some very interesting figures. This report was published in April, 1950.

* *Editor's Note:* The appointment of this Committee was authorized by the House of Delegates in April 1951, and its first report was presented at the Semiannual Meeting in September 1951. Dr. Moyers and his Committee have requested the Component Medical Societies to appoint local committees to study this problem, make suggestions and work in conjunction with the Faculty Committee, which is composed of the following members: Wolcott L. Etienne, M.D.; Houston Everett, M.D.; Thomas K. Galvin, M.D.; Frank J. Otenasek, M.D., and Waldo B. Moyers, M.D., Chairman.

Tuition, books, fees, etc. (excluding living expenses).....	\$3,500.00
Amount lost—9 Yrs. training.....	26,500.00
<hr/>	
Total.....	\$30,000.00
Interest.....	5,000.00
<hr/>	
Total.....	\$35,000.00

Cost of carrying this load

1. Interest 4%.....	\$1,400.00
2. Cost of annuity of this amount per yr.....	\$800.00
3. Cost of running an office.....	\$2,200.00
4. Earnings necessary to meet these expenses.....	\$50,000.00

Specialty training would probably add about \$10,000.00 to the cost.

When a doctor wishes to improve himself and practice better medicine he takes postgraduate work. During this period he loses his income, his expenses go on, and he has to pay all expenses for his training. The Bureau of Internal Revenue has ruled that post graduate education is a personal expense and not deductible. This makes it very difficult for a doctor to try to improve his medical ability because of the economic problem.

With the above factors in mind how can a young doctor prepare for the future of his family and himself? His so called capital assets, produce income only while he can work, and have no value to his family after he dies or is disabled. The older men, who had good incomes before the income tax became so high, are in much better condition economically but what of their children and grandchildren who wish to study medicine? The inheritance tax will soon bring all to a common level and the income taxes are increasing every year.

Your Committee for the Study of Certain Phases of Medical Economics begs you to think about this problem and help by setting up a committee in your society as we have requested through your president and secretary.

We advocate three changes in the present laws and we feel that this movement will have to be started at

a State level. If enough States will do this it will be much easier to get national legislation. If something is not done to alleviate this situation the only answer is government subsidies and eventual control.

The three changes are as follows:

1. Legislation to allow deduction or amortization of the capital assets involved in all technical

and professional training over an appropriate period of time.

2. Deduction of postgraduate education in the same manner.
3. Setting up of retirement funds during active practice, taxable only on payment from fund to the doctor.

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

This Committee, sponsored by the Maryland Division of the American Cancer Society and authorized on April 23, 1951, by the House of Delegates of the Medical and Chirurgical Faculty, has been in operation since September. The purpose of the Committee is the study of delay periods in the treatment of pelvic cancer and to attempt to reduce these delay periods. The Committee is established along the lines of similar Committees in Philadelphia and Boston, where successful studies have been conducted over the past several years.

The following Baltimore hospitals are cooperating in the study: Baltimore City Hospitals, Bon Secours Hospital, Church Home Hospital, Johns Hopkins Hospital, Lutheran Hospital, Sinai Hospital, University Hospital and Women's Hospital.

All ward and clinic patients with pelvic cancer who are being treated in these hospitals may be inter-

viewed by our secretary. Private patients are interviewed at the request of the visiting doctor. From the data thus collected, cases are selected for discussion at the monthly meetings of the Committee. All doctors concerned with the cases are invited to attend the meetings. It is the hope of the Committee that by open and frank discussions of the problems in diagnosis and treatment of pelvic cancer, that the delay period which often occurs before adequate therapy is initiated, may be reduced.

Abstracts of case histories and discussions held at the meetings will appear in future issues of this Journal.

Meetings are held the third Thursday of each month from 5-6 P.M. in the Medical and Chirurgical Faculty Building. All physicians are cordially invited to attend these meetings.

SYMPOSIUM ON MEDICAL ASPECTS RELATING TO EUTHANASIA

Arranged under the auspices of the Symposia Subcommittee of the Medicolegal Committee of the Baltimore City Bar Association and the Medical and Chirurgical Faculty.

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, March 28, 1952, 8:00 p.m.

PANEL DISCUSSION

MR. JOHN S. STANLEY, *Moderator*

President, Maryland State Bar Association

1. Historical Development of Euthanasia. George Boas, Ph.D., LL.D., Professor of the History of Philosophy, The Johns Hopkins University.
 2. Legal Aspects Relating to Euthanasia. Charles E. Orth, Esq., Formerly Assistant State's Attorney of Baltimore City.
 3. Medical Aspects Relating to Euthanasia. Louis Krause, M.D., Professor of Clinical Medicine, University of Maryland School of Medicine.
- Questions from the floor.

Scientific Papers

PANEL DISCUSSION: PEPTIC ULCER¹

The Baltimore City Medical Society held a Panel Discussion on Peptic Ulcer, on Friday, November 16, 1951, at 8:30 P.M., at the Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore 1, Maryland, with Dr. Louis A. M. Krause, President, presiding and Dr. Harvey B. Stone as Moderator.

HARVEY B. STONE, M.D., *Moderator*

Will the members of the Panel come up front and take their seats? I think Dr. Fort and his Program Committee have been eminently successful at least in advertising this occasion as the attendance is better than I have seen at a Society meeting in some time. In the choice of subject, it seems to me, they have been very wise because peptic ulcer is a condition certainly of widespread occurrence and apparently increasing frequency. I think if one can believe the things read in the newspapers and elsewhere, peptic ulcer has become a sort of class distinction. The Hollywood Producers and business executives seem to feel they are not really in the first rank unless they can lay claim to possession of peptic ulcer, and I have had the feeling frequently in taking the history of patients that maybe the diagnosis of ulcer is more frequent than ulcers. It is not at all uncommon for a patient to tell me "five years ago I had a duodenum ulcer, I was treated for it for about three weeks and got over it and haven't had any trouble since." Now that is entirely possible but it has provoked a certain amount of skepticism on my part as to the ease with which the diagnosis of peptic ulcer seems to be made even by the general public; apparently if somebody has some digestive disturbance and a little

bit of pain it is assumed as a matter of course that he has peptic ulcer.

I might say there has been some criticism as to the title of the subject we have tonight. Certain purists claim that the term "peptic ulcer" in itself is a misnomer, that there is no evidence at all to show that pepsin *per se* has much to do with the development of these ulcers, and that another name, a more exact name, should be adopted. However, peptic ulcer is a term of such wide acceptance and established usage, it is foolish to quibble about a word of that sort.

Just a remark about the operation of the program tonight. These gentlemen sitting beside me constitute the panel who will present various aspects of this topic from the point of view of the specialty or general field in which they themselves are active. At the end of these talks, the meeting will be thrown open to general inquiry;—not general discussion but general inquiry. We cannot, unfortunately I think, manage the meeting if people just get up and ask questions. Questions will have to be submitted in writing and it probably will happen that a good many people will submit the same questions so there will be a good deal of overlapping. I might say we already have a number of questions, sent in prior to the meeting, and there are at each seat pieces of paper on which anyone is invited and urged to submit a written question. At the end of the

¹ Presented before the Baltimore City Medical Society, Friday, November 16, 1951.

formal presentation tellers will collect those papers and we will try to organize them and submit them to one or more of the speakers on the panel, directing the question to the man or men in whose bailiwick the question most naturally fits.

Now you know all these people, but I should like to introduce them in the order in which they will speak and identify them as to the particular field which they will cover. Dr. Sherman M.

Mellinkoff will talk from the standpoint of the Internist and General Medicine; Dr. John Tilden Howard will speak from the standpoint of the Gastroenterologist; Dr. Jacob E. Finesinger represents Psychiatry in its interest in Peptic Ulcer; Dr. David M. Gould, pinch-hitting for Dr. Russell Morgan will take care of the Roentgenological aspect of the topic, and Dr. C. Reid Edwards will speak for the Surgeon's standpoint of it. Now, Dr. Mellinkoff can you lead off?

INTERNAL MEDICINE

SHERMAN M. MELLINKOFF, M.D.

I don't know whether Emily Post was the first one to say this but it is certainly true: One excuse is always preferable to two; and much more convincing. If that be true we are in for a bad evening, because it would appear that we all know so little about peptic ulcer that we have had to get six men to tell about it. I think however, it is well to begin by admitting that after all the years of research in this field, we do not know exactly why some people get peptic ulcers and others do not. I think about all we can say in that regard is to list a few things we do know, admitting they are not the whole story.

The first thing we know about the pathogenesis of peptic ulcer, I think, is that it is practically impossible, or at least by definition impossible, to have a peptic ulcer without free hydrochloric acid. While there are rare instances reported in the literature of benign ulcers in the stomach and even rarer ones in the duodenum in which there was histamine achlorhydria, it certainly is true that in several thousand cases of true histamine achlorhydria, such as patients with pernicious anemia, no true ulcer has been found in autopsy series.

I think the second thing that has been shown in human beings as well as in Dr. Wangenstein's experimental dogs, in Minnesota, is that peptic

ulcer is found more commonly in animals or in men who have been subjected to emotional or physical trauma. Dr. Finesinger later will discuss, I presume, the particular types of emotional trauma that lead to peptic ulcer formation. It is interesting to note that varying types of trauma will lead to peptic ulcer in dogs. This seems to tie in with the fact that severely burned patients or patients who have been through severe accident are liable to develop acute ulceration.

The reason for this relationship is not known but I think that the recent findings in regard to peptic ulcer with ACTH may have some bearing on this subject. At least it is refreshing to find that ACTH will not cure peptic ulcer, and even that ACTH will make it worse, and it is interesting that ACTH is produced in response, as we all know, to any number of different non specific stresses such as burns, fractures and emotional stimuli. Why ACTH behaves that way pushes the problem one step farther but not much nearer solution. We might mention that it has been shown that ACTH will increase the output of hydrochloric acid and pepsin in a normal stomach; whether that is the whole story is a very debatable point.

Finally, why it is that certain kinds of brain lesions such as ordinary strokes and certain kind

of brain tumors will predispose to peptic ulcer formation I cannot say and perhaps Dr. Finesinger could shed some light on that subject.

As to the symptoms of peptic ulcer, I certainly would agree with Dr. Stone that the diagnosis is often made when the disease is not present, and would like to add subject to his approval, on the other side of the coin, that the diagnosis is often not made when the ulcer is present.

Recently, I went through the charts of thirty-nine patients with duodenal ulcer we had seen in the G.I. clinic at Johns Hopkins in the last two months. In over half of these the patient had suffered dyspepsia of various kinds and had been treated and mistreated with a variety of medications between two and twenty-five years before the diagnosis of peptic ulcer was made and before proper therapy was instituted. I think this is an important thing to remember, because peptic ulcer is so much easier to treat, than is "indigestion" about which the doctor has no conviction. If he can tell the patient and tell himself that he knows this patient has a peptic ulcer he is much more apt to give intensive and adequate treatment, than if the patient remains somewhat of an enigma probably representative of "functional indigestion."

In these thirty-nine patients the same thing has been found with regard to symptomatology as has been pointed out by Bockus and many others in going over thousands of cases of peptic ulcer. That is, that almost any kind of indigestion may be produced by an ulcer and in fact ulcers may bleed, perforate and stenose without prior symptoms. However, two characteristics, if anything is characteristic about this group are: (1) The cyclic nature of the disease, by that I mean the fact that those who had symptoms for a long time tended to have bad periods when pain or nausea, or whatever the discomfort, was present almost constantly, and other periods when they felt perfectly well for long periods and had no symptoms whatsoever. (2) The second thing that was characteristic about the symptoms of the patients in this group, was food relief.

There was nothing on physical examination to indicate uncomplicated peptic ulcer except perhaps an appraisal of the patient's psychiatric and emotional background and that will be discussed by Dr. Finesinger. The only sure way I know of to make the diagnosis of peptic ulcer, objectively, short of the occurrence of some catastrophe such as hemorrhage, is by x-ray, and Dr. Gould I presume will discuss the x-ray diagnosis of ulcer.

I would like to go on record with reference to gastric analysis, and perhaps start a controversy by saying I think gastric analysis is highly overrated. I cannot attach much importance to it, except that it may demonstrate achlorhydria. Degrees of hypochlorhydria, or hyperchlorhydria don't help me, I would be interested to hear what the others have to say about it, particularly Dr. Howard because there is so much overlapping between the amount of acid the normal person will secrete and the amount secreted by a patient with an ulcer. This is further complicated by the fact that whereas the mean hydrochloric output in duodenal ulcer patients is higher than normal, the mean hydrochloric acid in gastric ulcer patients is not higher than normal and in many series is even lower than normal.

With reference to treatment of peptic ulcer Dr. Howard is going to discuss its pharmacological aspects, Banthine, atropine and diet, etc. I would like to say; that it is frequently less important what the patient is eating than what is eating the patient. At least we have the best results, I think, in our clinic with patients who come in whenever they are upset, not necessarily whenever their stomachs are upset. It seems to me that is the best way; careful watching of the patient in those periods is the best way to avoid complications of ulcer such as hemorrhage, perforation, stenosis and intractability, which I presume Dr. Edwards will discuss.

Finally, I would like to raise one question for other members of the panel to shed some light upon and perhaps for all of us tonight to think about, that is, the problem of gastric ulcer in

carcinoma. I think this is one of the most highly controversial subjects in the whole peptic ulcer problem. As everyone knows, it is impossible to tell a benign ulcer of the stomach from a malignant ulcer by the symptoms, by signs, or x-ray except in a minority of circumstances. Because of this, people at one extreme of this argument, such as Dr. Ravdin of the University of Pennsylvania have suggested that as soon as the diagnosis of gastric ulcer is made, the patient should undergo exploratory laparotomy and at least subtotal gastric resection, depending upon the findings. At the other end of the pole are those who

say gastric ulcers, if they are on the lesser curvature and if there is free hydrochloric acid present, and if there is no obvious evidence of malignancy, are statistically much more likely to be benign than malignant. Therefore, and particularly in consideration of the low cure rate from surgery in gastric carcinoma, these patients should be given a thorough medical treatment and operated upon only if that fails. My own view about this is perhaps closer to Dr. Ravdin's than the other end, but I would be very happy to hear the other side of this controversial subject.

GASTROENTEROLOGY

JOHN TILDEN HOWARD, M.D.

I want to talk a few minutes about the treatment of ulcer. But, before I begin that I will give my opinion on a few of the questions which Dr. Mellinkoff raised. I *do* think that the determination of gastric acidity is of some value. Of course, in gastric ulcer the acid may be perfectly normal and usually is within normal limits; a determination of gastric acidity in these cases is of little value unless achlorhydria is found. On the other hand, in cases of duodenal ulcer, I am sure that most, though not all, have hyperacidity and hypersecretion. In working rapidly, as we have to do in these days when one doesn't have time for fractional gastric analyses, a determination of the volume and acidity of the fasting stomach juice is often a diagnostic aid but I don't believe that it makes the diagnosis.

Dr. Mellinkoff brought up the question of ulcer and carcinoma and how they should be treated. I think that about five per cent of gastric ulcers become or are malignant and look the same as benign ulcers on the roentgen films. I have just heard Dr. Ochsner say in the past few days that he believes every gastric ulcer should be operated on and that he supports Dr. Ravdin

entirely. He says, "How will we ever improve our mortality rate from gastric cancer unless we operate on suspicion?" And he goes so far as to say that everybody who has anorexia and who is beyond the age of forty-five should be explored surgically, even though there is no demonstrable lesion. That, I think is a bit far-fetched, but he says he has done that in the past two years in three or four cases and he has found a cancer every time. He didn't mention the mistakes he made, if he made any. My own feeling is that conservative measures should be given a trial, even though the surgeons are getting so good they can look in and resect a stomach on suspicion and get away with it. I'm in favor of conservative management for three weeks at least of gastric lesions that are roentgenologically and gastroscopically and historically benign and when free acid is present. It seems to me that one will make an awful lot of mistakes and take out too many stomachs which can be salvaged with medical treatment if he operates on suspicion or requires no more than the presence of gastric ulceration to send his patient to the operating room. I shall go a little further

than that and say, we used to hear that all prepyloric lesions were malignant. I have seen many lesions around the pylorus which were benign and, contrary to the old idea, ulceration on the greater curvature near the pylorus may be benign. They have often disappeared with a little medical treatment and they have not returned. Have I missed curing some cancers by continuing medical treatment too long? Yes, I've made some mistakes but I think my successes have far outnumbered the mistakes in diagnosis.

Now we all agree that in the treatment of peptic ulcer we want to relieve the symptoms, to heal the crater, and to prevent recurrences. Also I think we will agree that the natural cycle of the ulcer is in our favor. If we don't do anything of consequence, the patient is quite likely to get better. Almost always, when the patient comes to us, he says, "Yes, a couple of years ago I had an attack like this," or "I've had three of four attacks and they passed over." We do not see the patient when the ulcer begins. I sometimes wish we had some way of looking into the duodenum of persons with no more than dyspepsia (I suppose we will have that one day) to find out if there is ulceration. I'd like to diagnose peptic ulceration before the lesion is deep enough to produce a defect on the x-ray. That would be the ideal time to institute treatment. But when an ulcer is found, I think we all feel that the pepsin-acid mechanism should be put out of commission and that can best be done by keeping the acid low, by neutralizing what acid is secreted. To do that, the Sippy regimen was started and, when I came to Baltimore twenty-five years ago, I thought that anybody who wasn't treated in the Sippy manner, that is, with feedings of milk and cream every hour and with an alkali midway between each feeding, was being treated terribly. He wasn't getting the very best. But it wasn't long before I learned that the patients who were treated on a less strict regimen did just about as well as a patient given a very rigid diet.

For the treatment of the usual peptic ulcer we don't put the patient to bed; we give him three

soft meals a day with milk and cream or chocolate milk or buttermilk or some palatable protein between meals and at bedtime. Then he is given the popular alkali of the moment. Just now the fashionable alkali seems to be aluminum hydroxide. I think that it is a good medicine but little doses of it don't have much effect. One should give larger doses than I used to prescribe; give a tablespoonful at a time, and not an hour after meals or half an hour after meals, but directly after meals. It's a nuisance to have to stop during a busy day to take a dose of medicine and I think that aluminum hydroxide may well be taken directly after meals. It should also be given at bedtime with the bedtime feeding.

When patients come from a distance they usually arrive with more or less hope and they expect to be helped at once, though they may not say so. For such patients who have peptic ulceration, rest in bed, atropine or Banthine, and calcium carbonate may work a kind of miracle. Calcium carbonate is a very rapidly acting alkali. If these patients have been taking magnesium trisilicate or something of that sort at home and if you give them about 4 grams of calcium carbonate at bedtime, they may say the next morning, "I had a good night, the best in a long time." And they are off to a good start with you—or you with them. Ordinarily, because of its constipating effect, I do not prescribe calcium carbonate; I give Alugel or Gelusil or some preparation of aluminum hydroxide that has a magnesium phosphate in it.

If the rather broad soft meat-free diet doesn't bring relief of symptoms quite promptly, I think one has to go back to the Sippy regimen, put the patient to bed, and give him larger doses of alkali. We always interdict tobacco, coffee and alcohol. I'm certain that coffee stimulates gastric acidity and I'm sure that most patients will take Kaffee Hag and Sanka without much complaint, if they will not substitute milk for coffee. To get users of tobacco to discontinue its use is not easy. But, if one talks to his patients plainly, he can get a very large percentage of them to cut down

on the consumption of tobacco if they don't stop it entirely. I always try to persuade patients with peptic ulceration to leave tobacco alone.

The barbiturates are very helpful to me in managing tense patients with ulcers. Recently in a New Orleans panel discussion on the treatment of ulcer a question was directed to the psychiatrist on the panel; the query was, "Are you afraid that you will get your patients addicted to barbiturates?" The psychiatrist replied, "Yes, that is a danger and it would be very bad." Though the question wasn't directed to me, I couldn't refrain from calling out, "I'd rather have my patient addicted to barbiturates, such as a little phenobarbital, than to tobacco if he had an ulcer."

Of the new anti-spasmodics, which are based primarily on good old atropine, I suppose that Banthine is the one that has been most advertised by the *Reader's Digest*, *Time Magazine*, and the news gathering services. The patient often comes to me with the idea that he should have Banthine prescribed and he may ask for it. Now Banthine does relieve pain, of that I am sure. But it does not in the doses that we can prescribe orally, say 100 mgm., affect the amount of gastric secretions in the least. In about twenty-five per cent of the patients who take therapeutic doses of atropine the secretion is diminished by the drug, so to diminish the amount of gastric juice in a patient with peptic ulceration atropine is of some use, but experience has taught me that Banthine is a better "reliever" of the pain of ulcer. Perhaps we give it in larger doses than we prescribe atropine. I am sure Banthine eases pain because of its relaxing effect on gastric muscles; it relieves spasm. The modern Syntropan and Trasentine haven't very much effect on gastric secretion though they do relieve muscle spasm. Tetraethyl-ammonium chloride isn't used clinically as a blocking agent because it lowers blood pressure so very much and makes the patient feel unpleasantly weak. However, it will temporarily lessen gastric secretion.

Researchers are looking for a drug that can

be given the patient orally or hypodermically at bedtime and which will keep his secretion of gastric acid minimal during the night. They will, I think, find such a medicine before long. If 0.3 mgm. per kilo of Banthine is given *intramuscularly* at bedtime, it will have a favorable effect on the acid secretion. My patients just don't like to take a hypodermic at bedtime for weeks and weeks and, as I said, Banthine by the oral route does not work on the secretion. There is coming on the market soon a new drug with the trade name Prantal which may be effective. I haven't used Prantal but I hear that it is a better drug than those that we have had. And another unnamed drug (called UO-385) is being tried for the lessening of spasm and of gastric secretion. It is said to be very efficient in lowering gastric acids and secretion when taken orally. The point is that the chemists are at work on drugs to lessen gastric secretion and that is what we want.

Enterogastrone you have heard about and it has almost been forgotten; it takes so much of it to produce an effect on gastric acidity. A psychic stimulus will raise the gastric acid promptly in spite of enterogastrone. You all know Kutrol (uragastrone). It costs fifty cents a capsule and it has been disappointing; it can't be depended on. It has been advised for the medical treatment of "intractable" peptic ulceration. In the difficult cases it has never been of use to me. The anti-histaminic drugs do not affect gastric acidity.

We have never used in these parts, as far as I know, roentgen therapy for the reduction of gastric acidity. Have you had experience with it, Dr. Gould? If it works, and they say that it does in Chicago, I wonder whether or not it slows down pancreatic function. How would it selectively inhibit gastric glands and skip pancreatic glands?

When peptic ulceration, particularly duodenal ulceration, resists the regimens that I've mentioned we may say that the ulcer is "intractable." If the surgical complications of hemorrhage, obstruction, and perforation can be excluded what medical complications may we look for?

As Dr. Mellinkoff suggested, we should look into the emotional fields of persons whose ulcers resist our simple treatment. The patient's ulcer may really not be so intractable; it may be that he has an intractable wife. When she is "reformed" or when he has been taught to accept her as she is, his ulcer may heal readily. A new boss has been known to relieve the symptoms of ulcer better than drugs. Then again intractability may result from failure of the patient to follow treatment prescribed. If one produces a pH of 4.0 or higher in the stomach and if he keeps it there the chances are one will make his patient comfortable. The average ulcer heals in three or four

weeks; then one may broaden the diet to a smooth one, keeping up the intermediate feedings and continuing this program six to nine months. The patient will often voluntarily continue with the principles of the smooth diet indefinitely. I always urge those patients who have stopped smoking to continue to get on without tobacco and on every ulcer patient I pin a White Ribbon and I ask him to remain on the "Wagon". Then, after such a so-called "cure," every September and every March and when the patient is under stress and strain he should return to the use of intermediate feedings and of alkalis.

PSYCHIATRY

JACOB E. FINESINGER, M.D.

Before beginning with my personal discussion I would like to say a few words about some of the remarks brought up by the other discussants. I think it is not too bad if you have an intractable wife because it is conceivable you can get rid of her, but if you have an intractable problem inside of you it is not so easy to get rid of it, and this may be a major source of difficulty.

There is a certain amount of evidence these days that emotions, such as anger, hostility, and resentment play a very important role in affecting certain gastric functions. You all know that Harold Wolff and his colleagues clearly demonstrated that these emotions can be an important factor in producing hyperemia, hyperactivity and hyperacidity.

Dr. Avery Weisman and myself in a study of the Massachusetts General Hospital attempted to investigate the symptoms, emotions, and personality of a series of 60 patients with peptic ulcer—established by x-ray diagnosis (Table I).

In working with patients, it is possible to have patients tell us details about themselves which are very specific. This first study was

based on the observations of a variety of patients. We tried to determine the incidence of frank psychoneurosis. This was done by interviews and by questionnaires. In this study psychoneurosis was defined in terms of symptoms; if you had certain symptoms then you had a psychoneuro-

TABLE I
Incidence of Frank Psychoneurosis

DIAGNOSIS	NO.	INCIDENCE
Patients with Fatigue.....	100	94%
Peptic Ulcer.....	59	64%
Atopic Dermatitis.....	62	22%
Healthy Sailors.....	37	18%
Healthy Pilots.....	150	18%

sis. In the series of fifty-nine patients with peptic ulcer we could make a diagnosis of frank psychoneurosis in over sixty per cent of patients. In contrast, in a series of one hundred patients with fatigue, and this is fatigue in patients whose physical examination was negative, the incidence of psychoneurosis was way up over ninety per cent. In the series of sixty-two patients with

atopic dermatitis the incidence was way down, about twenty-two per cent. As controls, we have two groups: a group of healthy sailors and a group of healthy pilots. In these two groups the incidence of frank psychoneurosis was somewhere between fifteen and eighteen per cent. This would indicate that there was a great deal of frank,

TABLE II
Exacerbations in Peptic Ulcer (60 Patients)

SITUATIONS	PREDOMINANT EMOTIONS
Work..... 36%	Anxiety..... 42%
Family..... 24%	Hostility..... 40%
Social..... 22%	

TABLE III
Onset of Peptic Ulcer (60 Patients)

SITUATIONS	PREDOMINANT EMOTIONS
Work..... 54%	Anxiety..... 36%
Family..... 26%	Hostility..... 32%
Social..... 20%	

diagnosable psychoneurosis in our series of patients with proved peptic ulcer (Table II).

In the patients with peptic ulcer we were concerned with the situational and emotional factors present when exacerbations occurred.

We divided the types of situations into three kinds—work situation, family situation and social situation. The data show that the greater incidence of exacerbations occurred in work situations. As to the kind of emotions present during these situations, anxiety occurred in well over forty per cent and hostility also to about the same degree (Table III).

It is easier to study exacerbations than it is to study the onset. We did see many patients at the onset of their illness. In studying the history of these patients we found three types of situation at the onset—work, family, and social work situations. The same types of feelings, anxiety and hostility, were present in about the same percentage as during exacerbations. This would make us believe that whether we are deal-

ing with exacerbations or the onset of peptic ulcer, the same situational and emotional factors were present (Fig. 1).

In studying the personality of these patients, we found in about two-thirds of the patients their personalities could be characterized as overactive, meticulous, overambitious, self-reliant, rebellious, and resentful. However, there were a smaller group of patients in whom one found a different sort of personality. These were compliant, conforming people who seemed to seek support and security. They were underactive, submissive and docile. We can distinguish people

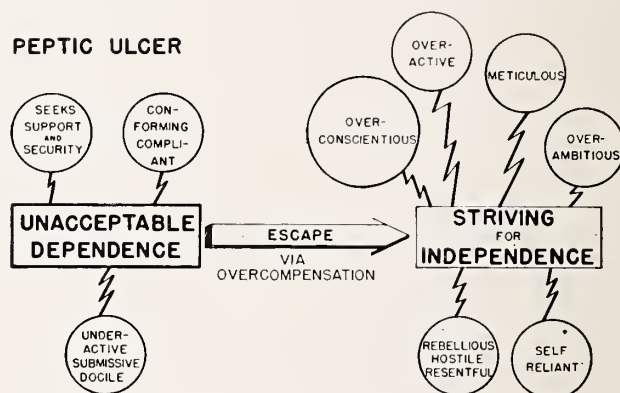


FIG. 1

who strive for independence, and who are ambitious in contrast to others who are dependent and have trouble in accepting their dependence. In attempting to explain this contrast, we fall back on a theory that maybe the basic personality type is the dependent type. These individuals attempt to compensate for their dependence by becoming overactive and ambitious. It is important to remember this is a theory.

The problem that comes up is, is there any relationship between the two types? In doing intensive psychotherapy with peptic ulcer patients one has surprises. You begin with an active ambitious type of person and during the course of treatment, especially if you go into difficult personality areas, you find that the patient changes. He becomes more dependent, more compliant, so we wonder, maybe this theory might be worthwhile thinking about.

Diagrammatically, this may be illustrated by circles representing the descriptive facts and the theory that one type of behaviour is a compensation for the other (Fig. 2).

It brings up the problem as to how these factors affect patients and how they affect doctors in working with patients. I was thinking as Dr. Mellinkoff made his apt remarks that it may not be so important what the patient is eating as to what is eating the patient. Sometimes what is eating the doctor may be important too. Basically what we had been inclined to do in therapy and treatment is to do something about these personality trends. We would like to moderate the patient's ideals if possible, we'd like to tone him down so he won't be quite so overactive. If the patient is dependent, we would like to make him accept his dependence if possible.

In doing any type of psychotherapy with patients, whether it be insight, relationship or support, these personality traits may get in the way of treatment. A patient who is rebellious with the outside world will also rebel when the doctor suggests that he do certain things. This hostility and resentment may come into the doctor-patient situation and complicate the doctor's problem in doing therapy. The same thing may happen with people who are inclined to be underactive. They tend to become more underactive

and this poses a problem which I am sure you are all familiar with in working with patients who have peptic ulcer. These personality characters operate whether you are doing psychotherapy or medical therapy or even surgery for that matter.

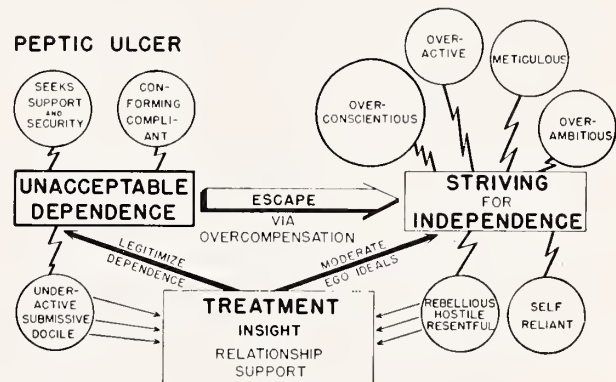


FIG. 2

I think it would be reasonable to say that there is enough evidence to indicate that emotional factors can be important both in precipitating exacerbations and in the onset. We also believe these personality factors are very important in treatment situations. We think they are good evidence to indicate that in the group of patients with peptic ulcer the personality types described above occur more frequently than other types. Why this is so is a question for discussion.

RADIOLOGY

DAVID M. GOULD, M.D.

I wish to comment on the point Dr. Howard brought up concerning x-ray treatment for ulcers. I know that x-ray treatment has been recommended for practically every existing medical ailment, however, the radiologist must keep a perspective based on rational therapy. While it may be true that sufficient roentgens delivered to the upper abdomen can decrease gastric acidity and the secretion of pepsin, the doctor must

bear in mind the price paid for achieving this end. I believe the price is too high. The liver, the pancreas, and the spleen would be unfavorably affected by the dose of roentgens necessary to decrease gastric acidity. The possibility of a roentgen induced cirrhosis or pancreatitis is too great a price to pay for the alleged cure of benign ulcers. I would not recommend roentgen therapy for gastric or duodenal ulcers.

My interest in peptic ulcers stems both from a professional and personal viewpoint. Fifteen per cent of my radiologic colleagues have duodenal ulcers. One of my closest associates, who was the epitome of emotional stability and perfectly asymptomatic had his ulcer ushered in by perforation. Since this event I have made no attempt to conceal my emotions. I hope that Dr. Finesinger approves of this course as a prophylactic measure.

The popularity of the roentgenologic method for demonstrating ulceration in the upper gastrointestinal tract is definitely increasing. Only four years ago I remember the average number of gastrointestinal series each morning was approximately fourteen. Since that time there has been a gradual increase so that now twice as many examinations are being made of the upper gastrointestinal tract and generally for the purpose of demonstrating an ulcer or carcinoma.

The radiologist concerns himself with visual evidence of the anatomical site and the gross pathological nature of the lesion. He is not primarily concerned with either the etiology or the histology of the lesion. If an ulcer crater is demonstrated and its size, position, and gross character is described, then the radiologist feels his task has been accomplished. From this point on, anything the radiologist says is in the realm of educated guesswork. He may know, for example, that very rarely does primary carcinoma involve the duodenal bulb, and therefore an ulcer crater in this portion of the duodenum is in all likelihood a benign peptic ulcer. He may also know that ulcers on the greater curvature of the stomach are rather frequently benign and therefore a greater curvature lesion would be viewed with the grave suspicion of malignancy. He knows the majority of ulcers on the lesser curvature side of the stomach, may be benign. However, statistical possibility of carcinoma is great enough that he must always entertain in his impression, the question of a malignant neoplastic process. The experienced radiologist is cognizant of many pitfalls. He knows that diver-

ticula of the stomach usually located near the cardiac orifice should not be confused with ulceration. He also realizes that a scarred deformed duodenal bulb may result in an out-pouching of one of the fornices of the bulb producing a pseudo diverticulum formation and that this should not be confused with ulceration. It is true that with thoroughness and experience, educated radiological guesswork can be of great clinical aid. However, I wish to underline the fact that the radiologic method cannot differentiate benign and malignant lesions.

For the diagnosis of ulceration the roentgenologist uses the roentgen ray in two ways. The first is the dynamic direct fluoroscopic method and the second is the detailed permanent record taken on the x-ray films by the roentgenographic apparatus. Both of these methods are necessary complements. The radiologist who uses the fluoroscope alone puts himself in a precarious position because the limitations in the brightness of the image and the sensitivity of the eye make it impossible for him to see great detail. On the other hand, the radiologist who depends upon films alone does not appreciate peristaltic activity, flexibility of the wall, and small ulcer niches which can be observed only in one particular projection and with the exertion of a specific amount of pressure here.

There is a great deal of art involved in fluoroscopy. In addition to a well grounded routine designed to exclude any gross organic lesion of the esophagus, stomach, and duodenum, the experienced radiologist develops a keen hunting eye. The way barium splashes down the lesser curvature, a slight aberration of the intricate mucosal pattern, a little hesitation in the peristaltic wave, a slight increase in rigidity of the stomach wall are signs to him that an ulcer or neoplasm may be lurking.

Classically, ulcers in profile form a niche or positive filling defect showing barium jutting out from the wall or lumen of the stomach or duodenum. Theoretically a carcinoma grown into the lumen of the stomach forms a negative filling

defect before an ulceration occurs. The classical case may be easy to differentiate, but most cases do not appear to be of the classical variety.

In addition to the silhouette type of visualization of an ulcer crater, I must mention that many ulcer craters, particularly in the duodenum can only be visualized "en face" or covered by the anterior or posterior wall. With a benign ulcer one frequently sees spasm of the wall opposite the ulcer, forming an incisura. Contraction of an ulcer tends to form radiating folds converging toward the crater. All too often, particularly in the duodenum, one does not demonstrate the crater. However, a scarred, contracted, and deformed bulb is accepted as excellent evidence of a chronic duodenal ulcer. Activity must always be judged upon clinical grounds. If we add up all our impressions of duodenal ulcer, I would estimate that we demonstrate 40% with an actual crater. The remainder have puckering, scarring, deformity, and pseudo diverticula formation. Many radiologists claim they can demonstrate a much higher percentage of ulcer craters.

There are three complications frequently seen in peptic ulcer patients. These complications are 1) perforation, 2) hemorrhage, 3) stenosis. Simultaneous occurrence of any two of these complications is quite rare, however, it is not uncommon to have a patient who presents himself with one complication, for example perforation, and gives a history of episodes of either hemorrhage or perforation.

Perforation of a peptic ulcer is a general radiologic problem. It certainly does not lie within the jurisdiction of the gastrointestinal fluoroscopist. There have been cases reported of the radiologist actually seeing perforation occur under his very eyes. The barium wells out from the lumen of the stomach or duodenum into the peritoneal cavity. This catastrophe I have never seen, nor do I relish the thought of seeing one.

The perforated viscus is usually considered by the radiologist when he sees free gas in the abdomen. When one suspects a perforated ulcer

it is customary to request a flat and erect film of the abdomen. On the erect film free air collects under one or both leaves of the diaphragm. If the case is not diagnosed, or the surgeon delays treatment, then one seeks radiologic signs of general peritonitis. If a paralytic ileus develops, one sees dilated gas and air filled loops of bowel. If free peritoneal fluid is present the soft tissue detail of the abdomen is obscured and the loops of bowel show separation.

If a patient has a bleeding ulcer, it presents a most difficult problem to the radiologist. No one can dispute that massive gastrointestinal hemorrhage is the most concrete evidence of an organic lesion. The radiologist looks for esophageal varices, he looks for a hiatus hernia, looks for neoplasm, and he looks for gastritis as well as ulcerations. In cases eventually proven to have a peptic ulcer it is a puzzle to me how frequently the lesion is not demonstrated on the first examination. The handicap of the very ill patient and non-manipulative examination may play some role, however, I believe that other factors exist. Perhaps a blood clot or marked inflammation of the mucosa hide the actual crater. Eventually with repeated examination I would estimate that we demonstrate the actual site of bleeding in little more than half of the patients.

It is probable that many cases of massive hemorrhage do not have a discrete ulcer but have gastritis. I have seen surgical specimens of stomachs with markedly enlarged gastric folds with a great number of superficial erosions. The diagnosis of hemorrhage due to gastritis lies within the province of the gastroscopist rather than the radiologist.

The last complication which I shall discuss is the stenosing ulcer. This condition occurs almost exclusively in the pylorus and duodenal bulb. The patient usually gives a history of a long standing peptic ulcer. Pathologically there is much scarring, deformity, and fibrosis which contracts the duodenal bulb to form a very small lumen. Radiologically we frequently see a very large stomach sometimes reaching huge

proportions and holding a gallon or two of fluid and food particles. Peristalsis may be very acute, or may be entirely absent. If the stenosis is of a high degree, the radiologist may find barium sharply contained by the pylorus and he may be unable to visualize the deformed duodenal bulb even with numerous observations spread over a period of hours. In cases such as these it is customary to obtain 5 hour and 24 hour films to see how much residual barium remains in the stomach. In my experience I have found that a stenosing ulcer is more apt to give a large stomach rather than an antral carcinoma obstructing the pyloric gateway.

A few traditional conceptions and misconceptions should be mentioned. I agree with Dr. Howard that the lesions close to the pylorus may be benign or malignant. There is an old radiologic adage which states that "within the first 3 cms. proximal to the pylorus the lesion is always malignant." I do not believe this adage. There

are a great many benign lesions in the pre-pyloric region, however, the incidence of malignancy is high enough to warrant an exploration. Another old tradition concerns the size of ulcer craters. It has been frequently stated that if an ulcer is very large, larger than 2.5 cms., then it is in all likelihood malignant. I do not believe that. Some of the largest ulcers that I have seen, measuring 4 to 5 cms. in diameter, have been proved benign.

I wish to emphasize that the prime goal of the radiologist is to demonstrate the anatomical location and the gross pathology associated with peptic ulcer. In the last analysis we cannot definitely distinguish a benign from a malignant ulcer. However, even with this limited goal we are constantly striving to refine our methods of making a definitive diagnosis of ulcer. Better contrast media, better spot film devices, more precise technique, and eventually fluorescent amplification will greatly enhance the accuracy of the radiologist.

SURGERY

C. REID EDWARDS, M.D.

I am sure there are many surgeons in the audience who would relish the opportunity of getting up and defending the position of surgery with regard to peptic ulcer. So far, this has been a very placid meeting. Dr. Fort called me, and when giving this assignment said there would be a lot of fur flying. Well, I don't see any evidence of it. I think it has been a very friendly meeting and I hope it continues to be so. The fact an opportunity has been given the surgical side to say something, means that there are some people who live in an "ulcer state" who can't get along under medical supervision and psychiatric talking.

Dr. Stone referred to some people who make the headlines, and even some prominent people who are victims of peptic ulcer, some proven,

some not. Unequivocally William Shakespeare was a brilliant man, and some lines of his come to my mind. I don't know whether he had an ulcer or not. There weren't any x-ray men to diagnose it; there weren't any internists to treat it; there weren't any surgeons to remove it, and he just had to live with it because a psychiatrist couldn't talk him out of it. He wrote: "There is a tide in the affairs of men which if taken at flood leads on to fortune, omitted—all the voyage of their life is bound in shallows and in miseries." So, there was a definite place even in the mind of Shakespeare for surgical intervention, possibly in ulcers.

I am very glad to hear an internist condemn the gastric meal. I have never seen the test do any good. The patient who has a painful ulcer

isn't awakened at two o'clock in the morning or later, or he doesn't have to leave his schoolroom in the middle of the afternoon because he has had a meal. He has pain on what country folks describe as "an empty stomach." I think a test meal with or without histamine or alcohol stimulation (and the meal itself is a stimulation) to prove that the patient has acidity, does not add to our knowledge of peptic ulcer. We know that he has hyperacidity, in a great majority of cases. What are we going to learn by giving him a test meal or alcohol or histamine or other stimulating agents except to increase his misery. I think we have to look at the patient who has an ulcer very much like we do the patient who has a carcinoma. I'm not as interested in what the pathologist tells me, as I am in observing how the patient behaves. One patient is operated on for carcinoma, and the pathologist gives the worst prognosis possible. That patient goes for ten or fifteen years without recurrence. Another one comes along with an apparently similar growth. A very hopeful prognosis is given by the pathologist and the patient is dead in six months with extensive metastasis.

A patient who has a peptic ulcer with moderate hyperacidity and a normal or slightly above normal secretion of gastric juice is not in the same clinical state with a patient who has a tremendous outpouring of gastric juice and a relatively low hyperacidity.

For instance, a big, healthy man, twenty-three years old, weighing one hundred and eighty pounds, a State policeman, suddenly collapsed. He had a gastric hemorrhage, was taken to a hospital, transfused, and gotten in good condition. The x-ray physicians were not sure, but they thought he had a duodenal ulcer. A month later, the same thing was repeated. He was again transfused and gotten in good shape. X-ray studies showed a small ulcer. Continuous overnight drainage obtained eleven hundred cubic centimeters of gastric juice with free hydrochloric acid of one hundred and thirty. That is a tremendously large quantity of fluid. Many patients

with an acute peptic ulcer will put out as much as fifteen hundred cubic centimeters of gastric juice in twelve hours even without stimulation. That type of person wakes up three or four times during the night complaining of pain. Continuous gastric drainage gives a very much better idea of the clinical behavior of the gastric mucosa than does a test meal.

There are a number of reasons for operating on patients with gastric ulcer, and one of them is bleeding. The patient with an active hemorrhage frequently gives an ulcer history of a number of years duration. Why do we have patients with such an extensive hemorrhage improve after transfusions, and then quickly become worse and have repeated hemorrhages? It is well demonstrated in the patient having duodenal ulcer with massive hemorrhage and subsequent operation. Pathological sections show the artery with an unorganized blood clot, thereby illustrating perfectly the old definition of a consecutive or reactionary hemorrhage. As soon as the blood pressure is built up and since the artery is sclerotic with no organization of the clot, blood flows out and the patient has another massive hemorrhage. There are too many cases which have gone through many hospitals in the past two years requiring fifteen, twenty, even twenty-five pints of blood to carry them over this episode.

A gastric ulcer with chronic crater base has fibrosis with sclerotic arteries. Such an ulcer will produce the kind of hemorrhage that we see so frequently in this type of patient. Any ulcer in the stomach presents the possibility of perforation and, of course, hemorrhage. A large ulcer is always interesting to a surgeon. He wonders what prevented the patient from having a perforation hours and days before its occurrence because at the site of the perforation there is a total absence of tissue oftentimes large enough to pass a five cent piece or even a quarter through it.

An ulcer on the lesser curvature is notoriously dangerous from the viewpoint of hemorrhage. When that type of ulcer is seen in the patient

with hypertension, it is, of course, very much more likely to produce massive hemorrhage. A former nurse from another State, diagnosed as having had a duodenal ulcer twenty-five years previously, developed malignant hypertension about a year before we saw her. A bilateral Smithwick operation had been performed. Patients with vagotomy or sympathetic operations for control of high blood pressure become less aware of symptoms. This woman suddenly began to bleed and in the course of two days required seventeen pints of blood to get her into condition for resection. At operation she pre-

TABLE I

Total Peptic Ulcers, University Hospital, for 5 Years—January 1, 1946 to December 31, 1950

(586 peptic ulcers represent 0.8% of a total of 65,425 hospital admissions.)

	CASES	PER CENT
Duodenal.....	384	65.7
Gastric.....	189	32.2
Marginal.....	13	2.2
Total.....	586	
Total Deaths.....	41	6.9

sented a picture of multiple ulcers and very active bleeding. Multiple ulcers in the stomach are not at all uncommon, and, of course, there are a number which are both in the duodenum and in the stomach. If patients could have an x-ray examination weeks and months before the development of complications, maybe x-ray people could demonstrate the location of the ulcers. However, many people who develop active hemorrhage have not had previous examinations. These patients present a complex problem to the internist and surgeon alike because of the emergency of the situation.

During a five year period there was a total of 586 peptic ulcer cases admitted to the University Hospital, or less than one per cent of the total admissions. Classifying the 586 ulcer cases according to location reveals that there were 384

duodenal ulcers, or 65.7%; 189 gastric ulcers, or 32.2%, and 13 marginal ulcers, or 2.2% (Table I). Of this entire series of 586 ulcer cases, 322 were treated medically with an over-all mortality of 7.8%, and 264 cases were treated surgically with a mortality of 6.1%. In both series, specific mortality rates varied with the location of the ulcer (Table II).

The mortality rate of those designated as medical was not due to the ulcer alone in a number of instances. Other serious conditions justi-

TABLE II
Treatment of Total Ulcer Series
(Surgical, 45.1%; Medical, 54.9%)

	SURGICAL CASES	MEDICAL CASES
Duodenal.....	138	246
Gastric.....	116	73
Marginal.....	10	3
Total.....	264	322
Total Deaths.....	16	25
Mortality.....	6.1%	7.8%

TABLE III
Presenting Symptom or Complication—Surgical and Medical Treatment

	TOTAL	SURGICAL	MEDICAL
Pain.....	352	148	204
Hemorrhage.....	134	26	108
Perforation.....	82	76	6
Obstruction.....	18	14	4

fied medical supervision and during the course of their hospitalization they succumbed. Post-mortem examination frequently revealed the presence of an ulcer as being coincidental.

These cases were divided according to the presenting symptom or complication. General subdivisions included pain, hemorrhage, perforation and obstruction. The predominant symptom in both the medical and surgical groups was pain, with 134 of the total peptic ulcer group having evidence of hemorrhage; 82 with perforation; and 18 with obstruction. Pain was the predominant reason for treatment in 352 of the total cases (Table III).

Surgical treatment instituted in these cases resolved itself into subtotal gastric resection, vagotomy, gastroenterostomy, simple closure of the perforation, or a combination of these procedures. The majority, or 177 cases, of the surgically treated patients received subtotal gastric resections, with a mortality of 6.7%. Vagotomy alone was done on 3 cases with a zero mortality. Gastroenterostomy was done on 11 patients with a mortality of 9.1% (Table IV).

Gastroenterostomies, of course, were reserved for cases too desperate to permit other types of operations. Something was demanded to overcome vomiting. This group of patients represented many derelicts. It is a difficult group, and

TABLE IV
Surgery Performed—264 Cases

PROCEDURE	CASES	DEATHS	MORTALITY
Resection.....	177	12	6.7%
Vagotomy.....	3	0	0%
Gastroenterostomy.....	11	1	9.1%
Closure of Perforation.....	64	3	4.7%
Combined Procedures.....	9	0	0%
Total.....	264	16	6.1%

even though gastroenterostomy is a rather simple operation, a high mortality must be anticipated because of a high urea and poor kidney function.

Closure of perforation was done on 64 cases with a mortality of 4.7%, and combined procedures, such as vagotomy and resection, or vagotomy and gastroenterostomy was done on 9 cases without mortality.

From a surgeon's standpoint it is extremely interesting to analyze the marginal ulcers. The marginal group having had previous surgery should help us evaluate certain inadequacies which may occur. It is interesting to note that the length of time between the original surgery and re-admission for marginal ulcers varied from 2 months to 17 years. In the marginal group the average elapsed period of time was 6.5 years.

Despite the recommendations for vagotomy alone for the control of marginal ulcer or of atropine or banthine or some other preparation, many cases of marginal ulcer are not going to respond to any form of treatment other than surgical excision. Of course it represents one of the most disappointing groups encountered, since previous surgery, performed to cure an ulcer, has become complicated by the development of a marginal ulcer. Antecedent surgery which had been performed on these cases comprised subtotal gastrectomy 6 cases; gastroenterostomy 6 cases; gastroenterostomy and vagotomy 1 case. Three of the marginal ulcer

TABLE V
Analysis of Surgery Performed on 10 Cases of Marginal Ulcers

In addition, 3 cases were treated medically without mortality.

PROCEDURE	CASES	DEATHS	MORTALITY
Resection.....	6	1	
Vagotomy.....	2		
Closure of Perforation.....	1		
Combined Procedures.....	1		
Total.....	10	1	10%

cases were treated adequately by medical means and 10 required surgical intervention (Table V). The predominant symptom in the marginal group was pain. Four of these cases presented complications, 2 of hemorrhage, 1 perforation, and 1 case presented a gastrojejuno-colic fistula.

It is now believed by surgeons over most of the country, that the end results of surgery as applied to a duodenal ulcer are dependent almost entirely on removal of enough gastric mucosa to guarantee a tremendous decrease if not a total decrease in the amount of acid secreted. Marginal ulcers are going to be seen in patients where deficient operations are done.

In reading reports from many clinics over a period of years, it will be found that the incidence of marginal ulcers has been reported from sixty per cent down to a minimum. Many clinics a few years ago, were reporting fifteen to twenty-

five per cent when they were doing gastroenterostomies.

In patients having a total or subtotal gastrectomy, meaning thereby the removal of at least seventy five per cent of the stomach, the amount of acid secreted following it is practically negligible. Whether or not this is the right thing to do is still in doubt. Certainly the reports from many clinics now show that the removal of seventy per cent of the stomach gives almost three times the number of satisfactory results

than can be obtained by any other method, including the medically treated.

There is no difference in the attitude of surgeons and internists now, in regard to peptic ulcers than there has been. Somebody said not long ago that the medical people try to control the ulcer state and the patient, and to keep the patient from the clutches of the surgeon and the postmortem table. He also stated surgeons try their hardest to take the patients from the medical people and cure them, and that is what we hope to do.

QUESTION AND ANSWER PERIOD

DR. STONE: This first question is really presented in three parts, but it really is one question, and although it is addressed to Dr. Mellinkoff, I would like to see what Dr. Howard and what Dr. Finesinger have to say about it.

Q. Has the existence of peptic ulcer notably increased in this country in the last twenty years?

Is this increase especially noteworthy in the negro population?

If there is an increase, do you attribute it to the intensification of pressure in the development of our political and economic environment?

DR. HOWARD: Yes, I believe that the incidence of peptic ulceration has increased and, since I feel that psychic factors have much to do with peptic ulceration, I attribute the increasing incidence of the disease to our complex and often frustrating economic and social environment.

It does seem that there has been a striking increase in the number of peptic ulcers seen in negro males. I'm inclined to the belief that conflict with environment plays an etiologic role. The young colored man who leads a simple life on a farm in Mississippi is probably less likely to have an ulcer than is his brother who goes to work in a factory in a northern city and who develops ambitions and resentments.

DR. FINESINGER: I have the impression that ulcer has increased in the male, I had a chance to go over some statistics. Fifty or seventy-five years ago ulcer was more common in female patients than it is today. I'd like to make one comment about the increased pace of living. The more we learn about ulcer—and about other psychosomatic disturbances too—the more we are inclined to believe the particular kind of stimulus, which may be responsible for reactions of this type, is a rather highly personal stimulus. It is the person's individual problem, his personal problem, his conflict, the kind of adjustment he happens to make, that is important in bringing about reactions of this kind. Whether those reactions occur more frequently in our current civilization is very hard to tell. I cannot add very much more to that.

DR. MELLINKOFF: As to the increase in the incidence of peptic ulcer, I think almost all the statistics that have been accumulated so far are open to a good deal of question because of the greater accuracy of diagnosis now as compared with twenty years ago. In Ivy's book on *Peptic Ulcer* (Ivy & Grossman), it is claimed that autopsy figures show that the incidence of gastric ulcer has increased in the past twenty years and that the incidence of ulcers among women has

increased. I don't recall any figures about ulcers in the negro population, but again I think the question of frequency of diagnosis would bear upon the statistics. I suspect probably there has been some increase in incidence of peptic ulcers. At least Ivy's figures gathered from all over the world would tend to bear that out. And as to whether that is due to increased pressure of modern living, I'm afraid I will leave that to Dr. Finesinger.

DR. STONE: One comment I might make in regard to the question of negro population. When I was an interne a good many years ago, it was almost unheard of to find a patient of the negro race with duodenal or gastric ulcer. It was really a great curiosity. At the present time, judging from the occurrence of the disease in Johns Hopkins Hospital, it is by no means uncommon, so that while I haven't any actual figures I have a firm impression that whatever environmental or other factors are of influence, in the occurrence of ulcer, they are beginning to affect the negro population, the negro race just as they do the white race. In other words, there has been a response of a similar nature which wasn't present forty or fifty years ago.

FROM AUDIENCE: May I make a comment? This is really not my business but I remember Dr. Halsted's work on peptic ulcer which was from figures checked in an Army Camp in North Africa during the last war. Apparently there were ulcers found in the negro patients. I forget the exact percentages, but I had the impression from the study that the type of ulcer found in these negro patients was primarily gastric rather than duodenal.

Q. DR. STONE: The next question is addressed to Dr. Howard particularly. Why the seasonal exacerbations in the spring and fall?

DR. HOWARD: I have no explanation but I'm sure that they occur. I know of no theories about them. I think it must be something like the weather and rheumatism; it is not understood. We all believe our patients when they say their rheumatism is worse in bad weather but we aren't able to explain why that is so.

DR. STONE: Does anyone else have any comment?

FROM AUDIENCE: I'd like to recall Dr. Friedenwald's work on this right here in Baltimore many years ago. He had an idea that infection had a tremendous influence on these peptic ulcers. In fact, it is mentioned in a number of text books that the seasonal upsurges, which he attributed to infections in the mouth and oral pharynx some of the text books attribute to seasonal respiratory infections.

Q. How long should antacid and dietary treatment be continued in patients who have been operated upon or have recovered under medical treatment and are symptomless?

DR. HOWARD: I think a reasonable time for careful medical management is about nine months. Then patients should try to live on a bland or smooth diet, limiting tobacco and alcohol forever. I always tell my patients that they have a chronic disease which may relapse. After surgery, I think three months on a bland diet is fair. They had their operation to get well. I say that a short period of dieting is a kind of insurance. Some surgeons will disagree with me, I know. They'll say, "Go ahead and eat everything after your operation, you had it so that you could eat everything!" But I ask them as a rule to be "good" for three months and then they can have carte blanche and eat as they wish.

DR. STONE: Dr. Edwards, do you want to comment on that slur on the medical profession—on the surgical group, I mean?

DR. EDWARDS: I think we should operate on people with the idea of curing them. I don't believe that any operation should be done for gastric or duodenal ulcer until the patient has had an opportunity to get well or to make marked improvement under medical supervision, but when the patient has reached the point that he cannot endure life any more then he should come to surgery. Once he has come to surgery the adequate thing should be done and then I don't think he should be a cripple. I don't think it is necessary to keep him on a rigid diet. He should be permitted to eat what he wants if it agrees

with him, and if he likes it, and he can get it in these days of high prices.

Q. DR. STONE: I hate to present a divided front from the surgical wing but I can't quite agree with that point of view. I feel that there's a question here that is later going to be directed to Dr. Finesinger. I feel the patient who has a peptic ulcer simply presents a symptom of an underlying dyscrasia, and that the removal of ulcer or the removal of part of the stomach or secretory mechanism of the gastric juice doesn't essentially convert that underlying dyscrasia into normality. We do know alcohol, tobacco, nervous strain and things of that sort are trigger incidents that set off the underlying disorder and I think that a person who has had a gastric resection may be cured of that ulcer, but he isn't cured of his underlying trouble and he ought to be regarded as a patient for the rest of his life. Now this question is along the same line and is for Dr. Finesinger. Granted that the psychiatric approach in therapy may be of value in diminishing incidence and intensity in ulcer development, do you think it is possible to modify effectively the real underlying psychosomatic basis on which these symptoms develop? In other words, can you alter the disorder which gives rise to these symptoms? You can stop the irritants and stimuli, but can you change the underlying trouble?

DR. FINESINGER: I think if I personally could change the underlying trouble, I'd be around collecting Nobel prizes instead of sitting here. One of the most troublesome and vexing problems that not only we psychiatrists have but also doctors and politicians and everybody else in this world has, is to change the basic personality of people. We do see changes in the underlying personality in many patients. This always reminds me of a story of Freud. Someone once asked him "why is it that psychoanalysis takes so long?" He said: "I don't know, you better ask God, he made the patients, I try to cure them and I find it takes time." At present our methods of basically changing people and basically

changing this ulcer type of patient are not too good. On the other hand, what is interesting is that a patient can have a certain type of personality for twenty-five years and then on a certain day apparently something starts and he begins to get an ulcer. I think one can differentiate between what you may want to call personality, and other events which occur in a patient's life. If we can do nothing else, no more say, than even controlling some of these precipitating factors, we think we are along the way. But another point I'd like to make too, is that when we speak about a patient or individual having a certain kind of personality, it is wise to remember he has that personality in a given situation. The so-called intractable wife isn't intractable every day in the year. Some days she is and some days she's not. What are the factors which make her more or less intractable? We believe that is the first area to approach in working with patients. It is quite possible for people to behave differently in certain kinds of doctor-patient relationships than they do in others. I cannot refrain from making a comment in reference to something Dr. Edwards hinted about. I haven't known a surgeon yet, and maybe I have a lot to learn, who doesn't use talk somehow or other. In spite of the fact that he may use other weapons, he also uses talk. Furthermore, I haven't known a patient yet who doesn't use talk so that fact remains that we all use talk. The question is can we use talk in a productive way, in a way which is going to help patients? I'm sure Dr. Edwards wouldn't mind for one moment if he could cure all peptic ulcer patients even with talk.

Q. DR. STONE: Dr. Finesinger, I don't want to overwhelm you at once, there are several other questions here. I'm not going to ask you to try them all. Here is one. Since passive dependence and striving for independence are commonly found in our culture, is it not possible the ulcer is a fortuitous finding based on the nature of the end arteries? Are not the same personality factors found in other so-called

psychosomatic entities like ulcerative colitis and in neurotic characters who do not develop peptic ulcers? In other words, I think the point of that question is that a great many people have these personality peculiarities that do not develop ulcer and isn't it necessary there be a combination of some local circumstance that leads to ulcer in one patient and something else in another of the same psychic type?

DR. FINESINGER: I think no one would ever assume that this is not the case. When people began to study these psychosomatic conditions, they had the idea that they would find a different personality type in every type of psychosomatic disturbance. What seems to be emerging is that there is a certain personality type that you would find most frequent in people who have hypertension, people who have mucous colitis, and people who have coronary diseases. There is another type of personality, the one mentioned in connection with ulcer, which one also finds in asthma. We would be inclined to believe before a person is able to have an ulcer that in addition to this type of personality a whole variety of other factors must be present. He may have to have a certain kind of stomach I suppose, and a certain kind of central nervous system. We'd be inclined to think there are a whole series of factors which apparently must be present before a patient gets any one of these psychosomatic disturbances. The therapeutic problem centers about the best way of dealing with the patient. We'd be inclined to be very practical and treat the factors in the patient that you can do something about. Sometimes surgery is indicated and sometimes we think talk is indicated. Our efforts at the treatment are determined by our information as to what is useful in the areas in which we can work effectively.

Q. DR. STONE: Dr. Gould, this question is for you. How dependable is the observation of gastric ulcer under treatment in determining whether improvement is taking place or not?

DR. GOULD: I do not think that improvement in an ulcer crater is a dependable criteria to rule

out malignancy. I have seen too many so-called benign gastric ulcers which appear to have improved clinically and radiologically, finally turn out to be malignant ulcers.

Q. Is it dangerous to fluoroscope a patient with recent gastrointestinal bleeding?

DR. GOULD: The consensus of modern opinion is that fluoroscopic examination of a patient with a recent gastrointestinal hemorrhage is not dangerous. There are large series of patients with acute gastrointestinal hemorrhages studied within 48 hours of the onset of the hemorrhage. One must take elementary precautions regarding the volume of blood loss and shock. Another necessary precaution in acute bleeding cases is that the fluoroscopic examination be non-manipulative. Theoretically it is true that with vigorous manipulation an ulcer that has been bleeding recently may dislodge a clot and start bleeding afresh. As a general rule the radiologist handles bleeding cases as delicately as possible. I do not remember a specific case in which recurrence or aggravation of hemorrhage was caused by a non-manipulative fluoroscopic examination. I frequently advise non-manipulative fluoroscopic examination and gastrointestinal series as early as 24 hours after the onset of hemorrhage.

Q. DR. STONE: You said in your primary talk that there were several formerly generally accepted conventional statements with which you could no longer agree. How true do you think is the statement that ulcers of the greater curvature of the stomach are predominantly malignant? Is that a general statement that still holds true or have you seen reason to modify it?

DR. GOULD: In my experience that statement is true. Whenever I see an ulcer of the greater curvature of the stomach, I view it with the deepest suspicion. The vast majority of benign ulcers are on the lesser curvature or close to it. When I see an ulcer on the greater curvature I try to convey to the clinicians that neoplasm is a very likely basis for this ulcer.

Q. DR. STONE: Dr. Edwards, I have been holding in reserve a group of questions that were

submitted by one of our surgical friends and I'm going to take them one at a time if you don't mind. What is your opinion of the so-called conservative or non-surgical treatment of perforated peptic ulcer?

DR. EDWARDS: To condemn it.

Q. DR. STONE: Do you feel it has not enough value to be given serious consideration?

DR. EDWARDS: I think if one sees a patient who has never had any surgery applied to his stomach and he has a perforation of an ulcer of the stomach or duodenum, he is a candidate for surgery immediately. If one has had a previous perforation and now he comes in with pain in the upper right quadrant, sharp in character, and the x-ray examination shows a bubble of air which may be either a diverticulum of the duodenum or it may be a perforation, it is already sealed. Conservative treatment in that case may be worthwhile, but I don't believe it should be done on a frank perforation into the free peritoneal cavity.

Q. DR. STONE: I'd like to sharpen up this matter a little more definitely because I think it is a thing that concerns everybody in this room. I would like to reinforce the opinion Dr. Edwards has just given. It seems to me not only there is no rational method in withholding operation but that it is an extremely dangerous thing to do or to advocate. Now this question I would like Dr. Edwards and then Dr. Howard to comment on. What are the indications for operation in peptic ulcers with massive hemorrhage and when should an operation if indicated be done?

DR. EDWARDS: I think a patient who has no history of previous trouble, and you can't get a history of an ulcer and he's a young person, you might be justified in treating him medically over a period of two or three days if during that time he shows improvement which is continuous and hemoglobin and blood count levels all show improvement. If however, he is an older individual, aged fifty or more, and has the history of a peptic ulcer and comes in bleeding actively, I think that he should get all that we are able to give

him, plasma, blood, watch him. Make hematocrit readings, blood count, hemoglobin estimates frequently, and if, after the administration of three or four pints of blood his hemoglobin level hasn't been tremendously increased, I think he is a candidate for surgery. About two years ago, we had a great number of these cases in a short time and the resident and I sat down and figured how much blood we could have saved in that month if we had subjected these patients to an early operation, and the amount totaled something like fifty pints. I think we are wasting blood in people who have marked sclerosis of the vessel. The bleeding is nearly always from the pancreaticoduodenal or one of its branches. It is a terminal vessel in a crater. There is no chance in the world for it to contract. It is too sclerotic, and I think that earlier operation is indicated in these people. One of the reasons for it of course has been well explained in many articles, the escape of the patient's own blood into his alimentary tract results in a very tremendous increase in urea level and a state of uremia is frequently responsible for death in these patients. Now, you can feed blood to an animal and it will digest it very well, but a patient who loses a great quantity of blood into his alimentary tract has a high urea developed very rapidly. The urine output decreases very rapidly and you are inviting a greater toxic state. Add to that the necessity of an anesthetic and an operation and I think that is where our mortality stays high.

Q. DR. STONE: Dr. Howard, will you continue?

DR. HOWARD: I think Dr. Edwards and I see eye to eye on that. My rule is that bleeding ulcers in persons under fifty are never treated surgically for their acute bleeding. They will always stop. After bleeding ulcer patients have passed fifty—and that isn't a hard and fast dateline—is the time to change your course in their management. Surgery may be needed. I agree with Dr. Edwards. Keep the pressure up; give them transfusions. I usually treat them vigorously for about six to twelve hours. Then I stop the transfusions and see if they are holding their blood. If they

go into shock again, if the pulse goes to one hundred and twenty, if the hematocrit falls, I think they are candidates for surgery after more transfusions. There is nothing like putting a ligature on a vessel.

Q. DR. STONE: Dr. Edwards gets this question, this is a long one. If an operation upon a chronic ulcer of a non-bleeding type reveals it to be in the pyloric area and it is adherent and difficult to mobilize, which is the better procedure, simple gastroenterostomy alone; gastroenterostomy plus vagotomy; vagotomy alone; partial gastrectomy with the exclusion of the pylorus; make every effort to remove the ulcer anyway and perform a routine subtotal gastrectomy or perform some other procedure not mentioned? It is perfectly obvious that that calls for the writing of a text book on the treatment of chronic ulcer, but I am sure that the purpose of the question is a very valuable one for this audience, because at the present time and for an indefinite period in the past, there has been a constant flux in the surgical opinion as to just what is the procedure to use in this type of ulcer. As all of you know, there has been a recent new contender for favor in the form of vagotomy. Now I think the purpose of this question could be condensed somewhat in this form. With a difficult adherent ulcer, what principles would you employ in this treatment?

DR. EDWARDS: Dr. Stone has very largely answered this question because it is a problem which is being discussed by surgeons always. It will depend of course, on the general condition of the patient, that is, is he a good surgical risk or not? It will depend of course on the general condition and on the type of anesthesia you employ; it will depend on the amount of blood available for the use of the patient during the course of the operation; it will depend upon the experience of the surgeon and then it seems to me the safest thing to recommend in a case like that is for the surgeon to carefully evaluate anatomically the situation and not do anything which he cannot undo. Now, when an edematous and

inflammatory mass involves a common duct and it may go on up to the hepatic ducts, any surgery directed towards removing that part is very likely to result in a biliary fistula and maybe a duodenal fistula. If the ulcer is penetrating deeply into the head of the pancreas, its enucleation is very likely to be followed by necrosis of the pancreas which will result in local abscesses and pancreatic fistula. I try to persuade our house officers who run into these cases, and try to follow such practice myself, that after evaluating it anatomically, to do the thing which anatomically can be done most safely. If it is to be a gastroenterostomy to relieve the patient of obstruction and you have a large calloused ulcer which has bled, the gastroenterostomy is not going to prevent other hemorrhages. It may be necessary to even open the duodenum and transfix the ulcer in order to prevent hemorrhage if you must leave it there. A text book would have to be written in order to emphasize in detail, but what I want to emphasize is that nobody can attempt to do a major operation on a difficult type of duodenal ulcer, go half way and then back out. It will result in necrosis, biliary and duodenal fistula and possibly a pancreatic necrosis and abscess.

Q. DR. STONE: Do you want to say anything at all about your views in regard to the value of vagotomy alone?

DR. EDWARDS: Vagotomy alone is not dependable, I believe. In this room Dr. Dragstead about three years ago, said gastric surgery would be of historical interest only. It is very interesting in going through his own clinic to find that many of the cases that he has reported and is working on all the time are kept in the hospital six and eight weeks as a part of the treatment, and I think there, the value of the internist and the surgeon and the psychiatrist are combined. It has been proven in too many clinics throughout the country that a vagotomy alone is not a satisfactory operation.

Q. DR. STONE: If x-ray and clinical evidence of an ulcer were found preoperatively, but at the

operation no ulcer can be found even after opening the stomach, is one justified in performing a gastrectomy and other definitive surgery and would the decision be altered if there has been recurrent hematemesis? The gist of that is, here is a case in which you expected to find an ulcer and didn't find it, what do we do about it?

DR. EDWARDS: If I opened the stomach and couldn't find it and the case had been worked up thoroughly, I would not remove any part of the stomach.

DR. STONE: I'd like to cite—this is not an occasion where cases ought to be cited, but in confirmation of what has just been said,—I'd like to cite a case which Dr. Howard knows about, of a patient upon whom I operated. He had sharp bleeding from the stomach, we thought, at least he vomited bright blood and there was x-ray evidence suggestive of a duodenal ulcer. I explored him and opened his stomach and could not find a thing. He bled afterward and ultimately it was found he had a curious blood vascular condition in the lower two or three inches of his esophagus. I cite that to show how sound the statement of Dr. Edwards was, that in those cases where you do not find objective evidence of a lesion that can account for bleeding in the stomach itself, it is silly to do a gastrectomy.

Q. DR. STONE: I find there are many more questions here but it is getting too late and I don't want to protract this session unduly and

kill whatever good effect it may have had by fatiguing you. There is just one more question that came up marked final. How often do peptic ulcers heal and stay healed? Dr. Howard, do you want to talk on that?

DR. HOWARD: I'm sure that peptic ulcers heal very often and that between relapses they remain healed. I'll admit that every once in a while one will see someone who has a crater demonstrated when he has no symptoms, but that is unusual. I believe the ulcer heals and then opens again some autumn or spring or when the patient goes on an alcoholic binge, or is under great strain. It is generally the same ulcer that opens up. Just a word about this presence of a crater in the absence of symptoms. I think it has been shown very definitely that banthine relieves the pain and yet the roentgenologists can still demonstrate the crater. But that crater will heal eventually. In most cases when a crater is demonstrated, the patient has symptoms and it may heal spontaneously or sometimes we may help it to heal. I think that we are of some use; we try to do good with our antacid therapy and with our measures for the reduction of gastric secretion.

DR. STONE: I just want to thank the members of the panel and to thank Dr. Fort and his committee for arranging the meeting.

The meeting is adjourned.

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MEDICAL AND CHIRURGICAL FACULTY RECENT APPOINTMENTS ON THE MARYLAND MEDICAL SERVICE, INC.

The Medical and Chirurgical Faculty has appointed the following Class "A" members of the Corporation, Maryland Medical Service, Inc.:

Dr. Warde B. Allan	Dr. Hugh J. Jewett
Dr. Robert P. Conrad	Dr. I. Ridgeway Trimble

Also in conformity with the By-Laws of the Maryland Medical Service, Inc., a panel of nine physicians to serve as a Reference and Appeals Committee, consisting of the following has been appointed:

Dr. Thurston R. Adams	Dr. John B. DeHoff
Dr. Lester T. Chance	Dr. Donald Hooker
Dr. E. T. Lisansky	Dr. E. Roderick Shipley
Dr. J. Mason Knox III	Dr. S. Edwin Muller

Dr. John W. Parsons

The last three named members serve on the Medical Relations Committee.

MEDICOLEGAL SYMPOSIUM—DRUG ADDICTION¹

Continued from the January issue

JUDICIAL ADMINISTRATION OF VIOLATIONS

HONORABLE JOSEPH SHERBOW

Judge of the Supreme Bench of Baltimore City

MR. THEODORE C. WATERS: The people of the State of Maryland, particularly the City of Baltimore take pride in the industry, wisdom and individuality of the members of the Supreme Bench of Baltimore City. Since his appointment and election to that office, Judge Sherbow has conducted himself in a manner that emphasizes the majesty and dignity of the law. When presiding in the Criminal Courts, he is ruthless in his determination to enforce the laws and punish all criminals without fear or favor. He brings to his office an understanding of the frailties of nature with due regard and sympathy to those who are victims of the use of drugs. I know I do not have to tell you of the wonderful job that Judge Sherbow has done and he will now discuss the Rôle of the Courts in the Administration of the Law Applicable to this Subject.

JUDGE JOSEPH SHERBOW: Thank you, Mr. Waters. Ladies and Gentlemen, my rôle today, as I understand it, is to discuss the judicial administration of the law insofar as Dope Addiction is concerned. The Lawyers know, but the Doctors and perhaps the general public does not know, that Judges in Baltimore rotate; they don't remain in one Court more than one year. I had never been in Criminal Court Part I before January of this year. I look forward to January 1952 as the happiest day of my life. I want to get out of that Court in the worst way possible, and I'm not referring alone to the situation as it deals with gambling. I'm referring primarily to the situation as it deals with narcotics in this City.

I have never seen a parade as degrading, as terrible as the parade of the addicts and the peddlers that we have had this year, and I have never felt so completely frustrated as I do now in October 1951, after nearly ten months in that court.

Let me give you just a little bit of history, and it is very recent history. I came into that Court in January. I had had a few months of experience in helping to organize the Youth Court—and I hope you will forgive me if I use the personal pronoun—but to get my point across I must talk to you on the personal level. In the Youth Court I had had four gangster-style bandits who held up some Loan Companies at pistol point, one after the other and robbed them. They were arrested and convicted. We went into those cases thoroughly and we found dope at the bottom of them.

That opened my eyes because I wanted to know more about it and when I was assigned to Criminal Court Part I, I thought the first thing to do would be to find out from the experts. So I asked Mr. Boyd Martin of the Federal Narcotics Bureau to come over to see me, which he did, and to borrow a phrase from the streets "I almost fell off my chair" when I found he had only three Narcotic Investigators for the whole State of Maryland—three, and they weren't always available for Baltimore.

Then I asked the Commissioner of Police if he wouldn't stop in to see me and I was astounded to find out that we did not have a Police Narcotic Squad. It was everybody's business in the Police Department; it was also the business of the Plain Clothes Squads, but we had nobody who devoted himself specifically to Narcotics.

Just about that time Judge Niles in the Youth

¹ Presented on Saturday, October 13, 1951, Osler Hall, Medical and Chirurgical Faculty Building, under the auspices of the Medicolegal Committee of the Bar Association of Baltimore City and the Medical and Chirurgical Faculty.

Court had a series of boys under twenty-one, who were charged with gangster-style banditry at the point of a gun and he went into it thoroughly and came up with the same answer—DOPE. Just at that particular time we had a murder case and the answer to the murder case was—DOPE. And I began to demand action—to try to make the public see this menace. One day there was an awakening.

We had three white boys who came from nice, middle class families—no different, no worse than the boys I went to school with—and they were charged with selling Marihuana. The day of their trial in that courtroom there were about eighty of the most strangely dressed boys and girls I have ever seen in my life. When you looked at them a little more closely you found they weren't youths, but some of them were as much as forty years of age. They had on "young" overcoats, and suit-coats, not like those we are wearing, but way down to the knees. You couldn't see the kind of shoes they were wearing, but my bailiff told me they had suede shoes on. They had a peculiar kind of pants, and long sideburns with the hair down this way and cut like that (DEMONSTRATES). We had girls sitting in the courtroom, the kind you would expect if you were going on a slumming expedition to the "block" in Baltimore, sitting there in the courtroom.

Then we had to announce that those cases were going to be postponed until the afternoon because some other cases were going to take up the whole morning. They all got up and walked out and I asked the bailiffs to mingle with them in the corridor. I want to tell some of you hardened doctors that the kind of language dealing with sex that went on out in that corridor is what you wouldn't even be familiar with; it wasn't filthy, it was so degrading it was disgraceful; it was awful and they were talking and using that language out in the corridor between Criminal Court Part I and the Grand Jury Room in the same way we say "this meeting will adjourn at such and such o'clock."

In the middle of those cases, one of the boys pleaded guilty and Mr. Lannigan of the Federal Narcotics Bureau took the stand to explain something. The lawyer turned to him and said: "There isn't very much involved in the fact these kids are smoking Marihuana, is there?" And I never saw a man's Irish dander get up the way Mr. Lannigan's did. He turned to their lawyer and said: "You don't know how bad the situation really is" and then for five minutes he let him have it. He told what Marihuana does and how it leads into Heroin. When he was finished I said, "Mr. Lannigan you told it to the wrong man, now turn around and tell it to that audience, just look at them and tell them." For five minutes he told them what was really involved—and they listened. I think that's the beginning in Baltimore City of a public awareness of dope. It hit the papers hard because nobody would believe that kids of fifteen years of age were selling eighty to ninety cigarettes, Marihuana cigarettes at the Knights of Columbus Hall, Eastern Avenue and Conklin Street on Friday night and there were more than two or three kids doing the selling. And that was only one spot—one public dance hall, and there are plenty more.

If I had a map of the City of Baltimore here, I could pinpoint for you right now areas in this city where there are young people less than twenty-five years of age congregating, smoking Marihuana and getting Heroin and I'll tell you where they are. Park Heights and Belvedere; Liberty Heights and Garrison; in the Hampden Section, two; in East Baltimore, at least three; in Northeast Baltimore, at least three. If you come from Roland Park or Guilford, or Catonsville, don't brush it aside, we've got the kids coming from the better neighborhoods, too, who are involved and who are being treated by psychiatrists and psychologists. You can't name a section of Baltimore City where we don't have cases.

I have on my desk today a letter from one of the doctors in this community, begging me to

do something for the son of his very dear friend who has become a hopeless addict. There isn't anything I can do except hope he comes to Baltimore and we can have him arrested. Then I can act. However, as long as he stays a few miles out of Baltimore City there is nothing that will happen to him because there is little enforcement there; they won't even know how to recognize the situation.

Now, what are we doing about this situation? I want to add to what Dr. Dearborn said, and that is that in addition to the habituation the strangest kind of phenomena takes place where a Heroin addict is involved. If you ask me to take a drink and at the moment I say I don't want it you don't press it on me. If you suggest a cigar and I say I'm not smoking at the moment and I don't take it, you don't make me take it. But if you are a Heroin addict somehow or other you're convinced that you just *have* to make the other fellow become one also. They have an insatiable desire to make other people addicts.

Well, we faced the problem, but what did we do about it? First, let me say, we did have the most remarkable cooperation in law enforcement that I have ever seen and I limit it only to narcotics. We obtained from the City authorities, Mayor D'Alesandro and the Board of Estimates, Ten Thousand Dollars for Mr. Sodaro's office. A Narcotic Squad was formed. I cannot give you high enough praise for the Narcotics Squad; at the appropriate time I propose to do something about it. Those men just work around the clock. You just can't work on an eight-hour shift where Narcotics are involved. Sometimes I wonder when they sleep. They are doing a wonderful job. We have at the moment any number of peddlers in prison. We have a large number of addicts in the House of Correction and elsewhere. A very few are out on parole.

WHY DO I FEEL FRUSTRATED? I'll tell you. We aren't doing anything for those addicts. I say and I repeat, we aren't doing anything for them. Very few can be sent to Lexington, Ken-

tucky. We do get a couple of them sent there. The Mayor and his Committee under Mr. Jett explored the situation insofar as Baltimore City is concerned with the idea of having some kind of a controlled clinic at the City Hospital. That meeting only took place the day before yesterday. We won't have any Control Clinics in the City and I don't think we should, because the City would be embarking on a program that would soon cost half a million dollars a year. It isn't the kind of a program that the City can handle by itself. Let me show you what it involves.

Under our system we have segregation and that means in a controlled clinic you have to divide the whites from the colored. Then you have to divide the male from the female and you haven't even begun to do your job because if you don't separate within that group by classification those who have a chance to be saved from those who are pretty much hopeless, you won't get anywhere. Now, after the withdrawal symptoms are past they walk around and there is nothing the matter with them except a craving for the drug which they would get the moment they got on the outside. You can't leave them in bed in a hospital. You have to find something for them to do, and more important than all of that, you have to give them psychiatric treatment. We don't have the personnel in this community for the job. The matter now is under consideration by Dr. Perkins and his group. The last word received from them was that perhaps by February they may be able to undertake some part of the job on the State level. I hope so but I doubt if we will have any beds for this problem by spring.

What do I do with the addicts when they are convicted? I send them to the House of Correction, I can't let them stay out on the streets. I do sometimes put a few good prospects on parole, but I get them back within a few months. In the House of Correction the Warden puts them out on the farm and they get along fine. Soon they want to get out and the minute they

get back to Baltimore, if the drugs are available, they'll get them. Even at the Lexington Hospital where they have the most intensive kind of treatment the percentage of success is not good. It's not Lexington's fault, it's the fact we haven't yet found an answer to the problem; we don't have any penicillin for drug addicts that will cure them.

What is the answer? Is it to impose harsher penalties? We now have laws requiring the imposition of heavier penalties. I'm going to ask the Legislative Council to amend the laws. The Legislature in passing the statutes has created some difficulty by making certain sentences mandatory. I see here in the audience today a distinguished, retired member of the Supreme Bench, Judge O'Dunne, who is responsible for one of the most important pieces of legislation we have ever had on our statute books. I refer to the O'Dunne Act which provides that no matter what the minimum sentence may be, *no* Judge is required to impose any minimum sentence. He can impose whatever in his judgment is proper provided he doesn't go beyond the maximum set by law. Judge O'Dunne in securing the passage of that statute gave to the Courts a weapon which we believe has been used most satisfactorily, but in connection with Narcotics the Legislature in passing this statute imposed certain mandatory requirements and it is not working well.

I have cases of drug addicts, whom I might be required under this statute to sentence to long, long years of imprisonment which would be wrong in their cases and tragic perhaps. If the O'Dunne Act were made applicable to that statute the Judge could impose whatever sentence was proper, provided it didn't go beyond the maximum. Whenever they read into a statute that a Judge must impose certain mandatory sentences they rob him of discretion and that means that two people who may have committed the same crime, one of whom can be rehabilitated and the other is a hopeless derelict must receive the same sentence. The importance of

the severity of the sentence does not mean too much to the confirmed addict. When he wants the drug it doesn't make any difference what is involved, murder, or prostitution, he or she will get the drug. The importance of the severity of sentence is to the peddler. We must put the peddlers away. They are not addicts, like the "gophers," "the pushers," who are little fellows and usually addicts. It is important to have this power to impose severe sentences on peddlers—and to use it.

In Baltimore we have law enforcement clicking beautifully on every front in the attack on narcotics. Yet we are as wide open as the Washington Boulevard, the Pennsylvania and the B & O Railroads and the Bus Lines that go to Washington. I tell you that I have to control myself at times when I listen to what these addicts say—and they are not repeating it for my benefit because their statements were taken weeks before, sometimes months. "Where do you get it?" "Such and such a street in Washington," Washington, Washington, always Washington! I tell you—and here I use measured terms,—I'm a Judge and I'm supposed to be careful in the language I use,—but I say the fact that the City of Washington, the Capitol of the United States, is the major source of Heroin supply for the City of Baltimore is an outrage and a disgrace.

I haven't even gotten to first base insofar as that charge is concerned. I have said this before the Senate Committees, I said it to the Grand Jury in my charge to them. It is a fact and it is obvious from these cases. As of today if there is anything going on over in Washington to stamp dope out we haven't heard about it over in Baltimore. Don't blame it on the Federal people, they still have only two or three operatives for a large area. It's a local Police enforcement problem and if the police won't go into that problem in Washington and break it up it won't be broken.

The original source of opium is Iran, Iraq, and other countries of the Near East. It gets to Italy where it is processed into Heroin and smug-

gled into this country. You could take this jar here (DEMONSTRATES WATER PITCHER), and it would be worth a quarter million dollars in Heroin in the illegal market because by the time it gets to the addict it is cut down with milk sugar to such an extent that that much pure Heroin would be worth a fortune. The same way twelve and a half pounds of Marihuana recently found in Baltimore will make forty thousand cigarettes; forty thousand cigarettes is worth twenty thousand dollars in the retail market.

The United Nations is making some effort on the international level. Remember how kidnapping was stamped out? In stamping out kidnapping we got harsh laws with severe penalties, but they weren't worth anything until we caught the criminal. There was relentless, unremitting pursuit of the criminals and it was stamped out. Today the younger group that are here don't even know what I am talking about when I say kidnapping was once a constant fear and threat to people in public life and the tremendously wealthy. That isn't so today. The Federal Government and the State Government each has a job to do.

I want to say one thing more. I'm not following any prepared address, but I want to make this one additional statement,—if you think it can't happen to people that you know; if you think it can only happen to people in the lower economic groups, to slum inhabitants, take my word for it, you are wrong. We can give you cases of children going to grammar school who were smoking Marihuana, one eighth grade school child of fifteen, and high school girls smoking marihuana, boys, numbers of them, doing the same thing.

If you ask me is there marihuana *in* the schools, my answer is that when girls going to high school in my day got into trouble, the trouble didn't happen in the corridor of the high school, it happened outside of the high school but it began in connection with their friendships made in school. Mr. Thomsen will discuss that phase with you.

I want to tell you I was almost made ill two weeks ago when I had a parade before me in court of kids—for that is what they were—white and colored kids who were involved in this dreadful mess. They started to smoke marihuana in automobiles around Belvedere and Park Heights Avenue; they even had parties in the club cellars of their own homes. One girl is all of seventeen.

How could she have started it, do you want to know? And this is why there should be real fear: "We were all in a car together and one of the boys had it and you were 'chicken' if you didn't smoke it, well, I couldn't be 'chicken' so I took a few puffs." And then the other girl got these girls to go to a hotel, not a second-rate or a third-rate, but a tenth-rate dive with older people where they were "turned on" as the vernacular goes, into the use of Heroin.

Now, are these addicts? I don't know. All I know is that every statement—and I read them all last night because I have to sentence them on Monday—everything I read was marihuana, heroin, heroin, marihuana and there isn't, with the exception of the person involved in the original peddling, one of them that is over twenty-five years of age. The parents of the fifteen year old child got her out of the neighborhood; as to the seventeen year old child the father pulled up lock, stock and barrel and moved out of the city with his daughter, thinking he could save her that way.

This is a most serious problem. Here are some of the things we have to do. First, we have to catch the peddlers and impose the severest penalties the law will allow on those peddlers. The addicts have to be treated, whether it be at the House of Correction, the Reformatory or in the Penitentiary, but they have to be treated. We have to destroy the source of supply so that when they come out of prison they won't be able to get the drugs. You will never destroy it in a city like Baltimore as long as it is so easy to obtain it just thirty-eight miles away in the city of Washington. As late as yesterday morning I conferred with some of our officials and found

out that Baltimore City is so tight that even the addicts are going over to Washington two or three at a time and taking the stuff over there for fear that if they come to Baltimore with

a cap—just one—the police are going to get them.

Now, there is the picture and it is pretty bad. Thank you.

CARE, TREATMENT AND REHABILITATION—NARCOTIC DRUG ADDICTS

JAMES V. LOWRY, M.D.

Community Services Branch, National Institute of Mental Health¹

The World Health Organization has defined drug addiction as follows: "Drug addiction is a state of periodic or chronic intoxication, detrimental to the individual and to society, produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: 1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; 2) a tendency to increase the dose; 3) a psychic (psychological) and sometimes a physical dependence on the effects of the drug." The care, treatment and rehabilitation of narcotic drug addicts is based upon consideration of the individual who uses drugs, the drugs the individual uses, and the environmental influences effecting the user.

Many persons have had narcotic drugs administered to them in the course of medical treatment of some illness. This, however, is rarely the initial step in addiction. Persons who become addicted usually are introduced to drugs by an addict. Those who continue to use drugs after the initial experience do so because drugs satisfy some need of the individual.

Some persons discover that drugs provide relief from anxiety, tension, fear, or fatigue. An illustration of this is provided by the following history: A male addict had a severe anxiety neurosis which was completely masked when he was using heroin. His distress during the withdrawal period was not remarkable, but during the period immediately thereafter, he be-

came increasingly tense, anxious, irritable and depressed. Three weeks after his last dose of drugs, he developed an acute anxiety reaction and suicided by jumping from an upper floor of the hospital. Some emotionally immature individuals discover that drugs provide the excitement, pleasure, and thrill which they continually seek. In some the rapid intravenous injection of the opiates produces an ecstatic sensation in the genital and abdominal regions that may be spread throughout the body. It apparently approximates the pleasurable feelings of a prolonged or intense orgasm. It should be remembered, however, that sexual drive is diminished or absent when the individual is addicted to opiates, and in women, menstruation usually ceases. With some persons the use of drugs is a component of aggressive, hostile, anti-social behavior. Others find that drugs can be utilized as a substitute for behavior less tolerated by society than addiction. An illustration of this is the case of a homosexual physician. He found that his homosexual drives disappeared when he was using morphine, thus enabling him to continue to practice medicine. When he became a medical officer in the Armed Forces, he was unable to obtain sufficient quantities to satisfy his needs. He resumed his homosexual activities which eventually resulted in his discharge. Once again he became addicted to morphine and practiced medicine successfully until he was apprehended for violation of the narcotic laws.

When the needs of the individual, whatever

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they may be, are satisfied by drugs, then that individual becomes emotionally dependent on drugs and is driven to their continued use. This condition is the cardinal characteristic of addiction—emotional dependence on drugs.

Many drugs are capable of producing addiction. Alcohol, of course, is the most widely used. Other sedatives of significance are the barbiturates, bromides and marihuana. The commonly used opiates are heroin and morphine. Of some importance are the synthetic analgesics Demerol and methadone. The only stimulants of significance with regard to addiction are cocaine and amphetamine. The continued use of any of these drugs results in emotional dependence upon them. Some—the opiates, the synthetic analgesics, and barbiturates cause physiological changes resulting in physical dependence. Once physical dependence has been established, drugs must be continued or the addict will suffer the agonies of withdrawal. To complicate the situation further, tolerance is developed for drugs that produce physical dependence. This means that to obtain the desired effect, the addict is required to take larger doses at shorter intervals. The opiates are almost always taken intravenously in order to obtain the maximum effect. The addict who uses opiates or synthetic analgesics is then driven by two compelling forces—the emotional dependence on drugs to satisfy his original needs and the dread of suffering if his physical dependence is not satisfied.

The treatment of narcotic addicts is impossible unless adequate facilities are available to keep the person in a drug-free environment. The difficulties of establishing such facilities in a general hospital are almost insurmountable. The desire to obtain the effect of drugs and to be relieved of the distress of withdrawal, prompts addicts to secure drugs by any manner possible. It is therefore imperative that rigid security precautions be taken so that narcotics are not available to addicts during treatment. On admission to a hospital the addict must be thoroughly examined to determine his physical status and to

look for concealed narcotics. In obtaining the history, the kind and amount of drugs used should be ascertained if possible, but one must remember that information given by addicts may be quite inaccurate. The addict who is buying illegal drugs has no way of knowing how much of the product he buys is narcotic and how much is some other substance like lactose. Many addicts are inclined to exaggerate the quantity of drugs they have used believing that larger quantities of drugs will be administered to relieve distress and pain during the withdrawal period. Inquiry must be made to determine whether barbiturates are used in addition to opiates.

Without appropriate treatment, the signs of abstinence begin about 8 to 16 hours after the last dose of morphine. The intensity, duration and variety of symptoms is related to duration of addiction and the dosage of drug used. First, the patient becomes restless and somewhat somnolent for a period of three or four hours. This is followed by lacrimation, yawning, sweating and rhinorrhea. The symptoms become increasingly severe and after about 24 hours are accompanied by muscle cramps, retching, vomiting and diarrhea. There is a continual restless moving about, whether the patient is in or out of bed and bitter complaint of being cold. A severe weight loss may occur within the first 24 hours. Fever, elevated blood pressure, respiratory abnormalities commonly occur. The symptoms increase in intensity for about 36 to 48 hours, continue for approximately 24 hours, and then decline over the period of several days. The patient is left in a weak, restless, irritable state of fatigue. It then requires about four months to return to what might be called a normal physiological state. Minor physiological deviations may last as long as six months.

Physical dependence is produced by the opiates—morphine, heroin, dilaudid, etc. and by the synthetic analgesics Demerol and methadone. The general symptomatology of withdrawal is similar to that described for morphine, but intensity of symptoms varies from drug to drug.

Withdrawal of heroin produces somewhat more severe symptoms and an earlier onset. The abstinence phenomena following withdrawal of methadone are mild in degree when compared with morphine. The onset is delayed and the duration is longer.

Prolonged use of large dosage of barbiturates produces physical dependence and the withdrawal phenomena may be severe. This has been demonstrated by Isbell,^{2, 3, 4} et al. under experimental conditions. About 24 hours after the last dose of barbiturates, abdominal cramps and vomiting may occur and the patient becomes irritable, tense, and weak. Some time within the next several days grand mal convulsions may occur. The patient may develop a psychosis which is usually preceded by an inability to sleep for several days. The psychosis is characterized by auditory and visual hallucinations, disorientation for time and place, and delusions. The psychotic reaction may last for several days to a month.

The present management of the withdrawal of opiates and synthetic analgesics is based upon the substitution of methadone for the drug used. This is indicated by concomitant administration of the addicting drug and methadone in the first 24–48 hours. Administration of the addicting drug is then discontinued and methadone is given over a 10–14 day period. One milligram of methadone can be substituted for four milligrams of morphine or for two milligrams of heroin if the dosage of the addicting drug is known. During the withdrawal period barbiturates are given at night if required. If dehydration results from vomiting and diarrhea, infusions of saline and glucose are administered. Methadone prevents the occurrence of most abstinence signs and when methadone is no longer administered, the distress is mild.

² Isbell, Harris: Manifestations and Treatment of Addiction to Narcotic Drugs and Barbiturates. *Med. Clinics of North America*, **24**: No. 2, March 1950.

³ Isbell H. et al.: Chronic Barbiturate Intoxication, and Experimental Study. *Arch. Neur. and Psych.*, **64**: 1, July 1950.

⁴ Isbell, Harris: Meeting a Growing Menace—Drug Addiction. *The Herzk Report*, July 1951.

Following the withdrawal period, four to six months are required for a return to normal physiological functioning. The patient's appetite increases and rapid weight gain occurs in the first thirty days. The patient becomes very optimistic with regard to his ability to live without drugs. Experience has shown that a discharge from the hospital at this time is almost invariably followed by a return to the use of drugs within a short period. Many addicts have physical defects which should be corrected, if possible. Those most commonly seen are respiratory and gastro-intestinal disorders. Some patients have illnesses requiring surgical intervention for the relief of pain. The discomfort of any illness will always remind the addict of the relief provided by narcotics and he may utilize any illness as a rationalization to return to the use of narcotics.

When the patient is no longer using narcotic drugs, the treatment is the same, regardless of the drug previously used. Treatment directed toward the primary problem—emotional dependence on narcotics. The treatment of the patient's physical dependence is a necessary preliminary phase. Treatment is then directed to the underlying factors that predispose the individual to the use of narcotic drugs. For those patients whose use of drugs is based upon a need to find relief from anxiety and discomfort of living, psychotherapy offers a chance of success. Following the withdrawal period, the treatment of the psychoneurotic addict differs in no way from the treatment of a psychoneurotic who has not used narcotic drugs. When the use of narcotics is a means of obtaining excitement and pleasure beyond that of normal social living, there will be less incentive to accept and participate in treatment. It is interesting to note that many of the emotionally immature pleasure-seeking individuals adjust themselves quite well to a rigidly controlled institutional environment. They find within themselves very little need to test the obvious limitations of the situation. They tend to conform with social patterns as long as they are under close surveillance. Such individuals should,

of course, be under supervision for a considerable period after they are released from the drug-free environment.

During the four to six months that the patient remains in the hospital following the withdrawal of narcotic drugs, there should be an effort to re-educate him to a reasonable manner of living. By the time an individual becomes addicted, his life has become so centered around the need for drugs and the ways to obtain them that he has become a practically useless social parasite. He has lost the respect of his family and his employers. He is no longer concerned with his appearance. He lives *in a world of fantasy* rather than reality when he has drugs; in a world of fear and panic when he is unable to obtain them. Having spent all of his available funds for drugs, he borrows, steals and begs from relatives and friends and may find it necessary to engage in thievery or other illicit activities to obtain money for drugs. One is thus presented with the problem, during the period of rehabilitation, of preparing this type of an individual for resumption of a useful, normal rôle in society. It is essential that the former addict be provided with regular work and be encouraged to live a more stable kind of existence by participating in responsibilities in the institution where he is being treated.

During the time the patient in the hospital is being prepared to return to a useful life in his community, attention must also be directed to the environment to which the patient will return. This requires an active social service program at the treatment institution so that the individual has some reasonable chance of obtaining employment, of being accepted by his family, and being given a fair chance by others when he returns to his community. Unless these conditions exist, the addict will be forced to seek out those people whom he remembers as his friends—drug addicts. Association with addicts is the most common method of relapse to the use of addicting drugs. Treated patients should be supervised for a period of approximately two years following their discharge from the hospital. It

must always be remembered that the use of narcotic drugs represents a flight from reality. If he is frustrated or unhappy on his return to the community, he will remember with pleasure the freedom from worry produced by narcotic drugs. The possibility of this escape mechanism may grow in his mind until he can no longer resist it. There begins once again the cycle of initiation of addiction, growth in habit and dependence.

In the recent past considerable attention has been directed toward addiction in individuals under age 21. Addiction in this age group is not a new phenomena, since a study by Pescor⁵ made 15 years ago of 1000 consecutive admissions to the Public Health Service Hospital, Lexington, Kentucky showed that 16 per cent had become addicted at 19 years or less, and 45 per cent were addicted by the age of 24. Research on the personality characteristics of younger addicts is now under way at the Lexington Hospital and a research grant has been made to support a study of the community aspects of addiction in this group. Until additional knowledge is obtained, the treatment of the younger addict will continue to be the same as for the older addict. Segregation of the younger addict from the older is probably advisable if it can be accomplished.

What are the results of treatment? Little information is available on the subject. At the Public Health Service Hospital in Lexington, an effort is made to follow the progress of the drug addicts for five years after their discharge. This, of course, is a difficult task. Many of the patients are voluntary patients, and follow-up is difficult if not impossible. Other patients are under the supervision of federal probation officers for a period, and because of this, information can be obtained. The hospital does receive reports on former non-voluntary patients who are arrested for narcotic law violation and this provides another method of follow-up. Realizing all the inadequacies of the available information, an

⁵ Pescor, Michael J.: A Statistical Analysis of the Clinical Records of Hospitalized Drug Addicts. Supplement No. 143 to the Public Health Reports.

attempt is made to determine the addiction status each year for five years following the patient's discharge. Information obtained indicates that 15 per cent of the patients remained off drugs for five years. About half the patients cannot be found and whether or not these people are using drugs is still an unanswered question. The remainder of the patients, some 35 per cent, are known to have relapsed to the use of narcotic drugs. A number of these who relapse do so after

periods of one, two, three or four years following discharge.

SUMMARY

The care, treatment and rehabilitation of narcotic drug addicts can, in general, be grouped into three phases: (1) the withdrawal of narcotic drugs; (2) the correction of physical defects and psychiatric care; and (3) rehabilitation and follow-up supervision.

THE PROBLEMS PRESENTED TO THE YOUTH OF THE COMMUNITY BY THE TRAFFIC IN DRUGS

ROSZEL C. THOMSEN, Esq.

Member of the Bar and President of the Baltimore City School Board

All four of the speakers you have just heard are what the sportswriters call "old pro's." They are experts on the subject under discussion. I am not even an experienced amateur. I have no competence to discuss the social aspects of the problem or to suggest legislative remedies; but I told Ted Waters that I would be glad to talk about what the schools in Baltimore are doing about the problem, what they can do, and what they should do.

1. WHAT THE SCHOOLS ARE DOING

Since 1938, most eighth-grade students have taken a course in hygiene, which includes a unit on narcotics. This unit was not especially designed to meet the current drug problems of young people, and is not effective for that purpose.

When the facts about the increased use of narcotics by young people appeared in the press last year, the senior high school principals met with Police Commissioner Ober and agreed upon procedures to follow in an effort to discover possible users of drugs and sources of supply. Teachers have referred to school nurses and doctors a con-

siderable number of pupils who were suspected of using drugs, but I am told that no user has ever been discovered in this way. Some pupils have reported information about sellers, and we understand that some arrests have been made as a result of this information. It does not appear that any sales are being made on school property. We have been told authoritatively by the local Federal agents that no person still attending school has been picked up as an addict in Baltimore in the past 36 years. The agents have arrested boys and girls 15 and 16 years of age who should be attending school, but they had left school and become delinquents.

Dr. Lillian Davis, Director of Health Education, has met with city, state and national health officers familiar with this field, and has worked with a federal interagency commission studying the problem. The Federal Narcotics Division has followed a "hush-hush" policy, and has taken the position that furnishing information concerning narcotics (under the guise of "education"), even in properly developed school courses, would do more harm than good. The schools have naturally given great weight to that recommendation.

Dr. Lemmel served on, and other members of the Department of Education met with, the Mayor's Emergency Youth Commission. They concurred in a statement to the general effect that it appeared inadvisable to overemphasize the problem, or to develop special courses dealing with it for use in the schools.

Members of the Department of Education have recently previewed a film dealing with this subject. They have also secured information about other films dealing with narcotics. However, they have discovered no suitable film.

At the beginning of the present school year, Dr. Lemmel appointed a Special Committee, including Principals, Counselors, Teachers and Nurses, to consider and recommend what the schools can and should do. This committee has held two meetings thus far, and has been asked to report as soon as possible.

2. WHAT THE SCHOOLS CAN DO.

The schools can do a number of things: e.g., they can teach teachers, they can teach pupils, and they can teach parents, the importance of the problem.

They can teach all teachers, principals, counselors and nurses to be more alert and skillful in detecting users, and in helping those whom they discover. They can teach certain teachers to conduct suitable courses for pupils at junior high and senior high levels, and to present information to parents simply and effectively.

The schools can provide suitable courses for all junior high and senior high students if it is decided that such courses are advisable. Those courses, in certain schools at least, might include a study of the dangers of other drugs besides marihuana and heroin.

The schools can present information to parents through P.T.A. groups, parent education classes, and in special meetings, where each school would make a great effort to reach as many parents as possible.

3. WHAT THE SCHOOLS SHOULD DO

Is it advisable that the schools do all or any of these things? I do not want our staff commit-

tee to feel that I am trying to anticipate their recommendations, or to influence their deliberations. The School Board wants, and knows that it will be given their honest and informed opinion. It will probably have to pass on questions of policy involved in those recommendations. Any ideas now existent are subject to change upon further advice and instruction from experts.

Certain things appear obvious. Children are learning about narcotics from many sources: television, radio, newspapers and comic books. Much of this material is sensational, stimulates curiosity and presents only a part of the picture. Many groups which are studying the problem have come to the conclusion that the schools can and should teach young people about the dangers, the misery and the disgrace attendant upon the illegal use of drugs.

The Final Report of the Senate Crime Committee contained the following statement:

"Education—The committee does not subscribe to the theory that public discussion of drug addiction should be avoided to protect nonaddicts from being tempted to try drugs. As in the case of venereal diseases, the attack upon which has been greatly enhanced by public knowledge, the committee believes that much will be gained by a carefully devised program of education designed to make the people of the Nation aware of the true facts regarding the excessive use of narcotic drugs.

* * * *

The committee believes that education should start in the schools and social organizations of the country and should be carried from there to the home. The basic responsibility for such a program rests on the shoulders of the country's educational leaders who should carry it forward at the local level."

I understand that the Federal Bureau of Narcotics now feels that parent education on the subject might be desirable. I believe the schools should make an effort to have all parents attend at least one meeting, and to advise them what they should do when they suspect or know that their children are using drugs. Some people do not like the idea of calling on Federal Agents. I suggest, therefore, that some appropriate agency establish two or more medical centers or offices,

at least one of which should have a Negro staff, where parents can freely go for advice and help.

Now that I have approached the subject assigned to me by making one suggestion, let me make one more. The Federal Government should provide institutions for the rehabilitation of youthful addicts separate from those institutions used for older addicts. In the existing institutions there is constant talk among the inmates about the effects of various drugs and where they can be obtained. That is about the only subject the older and younger addicts have in common. An institution set up especially for youths can take advantage of their interest in sports and other normal youth activities. Until the Federal Government acts, the State or City should make special provisions for youthful addicts. I understand that the Federal Bureau of Narcotics has

proposed that the City establish a controlled ward in the City Hospital for the treatment of young addicts, and that the matter is under consideration by appropriate City Departments. Difficult problems of segregation and custody are involved. We have a reasonable chance of curing the young addicts—if we can give them proper treatment before they have been using drugs for two or three years.

The critical problem is the youth problem—to prevent the use of drugs by young people from pyramiding to unmanageable proportions. As the Senate Committee said: "One of the great contributions that could be made to the welfare of the young people of today would be to bring home to them the cold fact that narcotic drugs are to be avoided like the plague." The schools can make a large part of that contribution.

QUESTION AND ANSWER PERIOD

MR. WATERS: I'm going to ask the participants in the panel to answer the question as promptly and concisely as they can. Our respective committees, from both associations, have submitted to the Chairman prepared questions to be directed to the panel. In addition to that I do hope and propose to allow a very limited time to the audience to direct any questions that they care to ask the panel. If I may so proceed, I'm going to turn the guns on our good friend Joe Sherbow because when counsel is in his Court it is not an unusual experience to have him direct not one question to counsel but several, and in the interest of saving time I'm going to ask him three questions that have had a mutual bearing upon the particular subject with which they deal.

Q. Judge, do you have any impression as to whether or not existing facilities are adequate for the care and treatment of addicts in the State of Maryland?

In your opinion should there be legislation to provide special facilities for this purpose and while you are speaking on those two questions,

Sir, would you kindly comment upon what the schools should do to assist in the control of traffic of drugs among teen-age individuals?

JUDGE SHERBOW: Let me try to answer these rather quickly. With respect to facilities in the State of Maryland, the answer is we have none, actually *N O N E*. All we have is a House of Correction and a State Reformatory. We have no place to send anybody for treatment. We could send them perhaps to the City Hospital but, they have no facilities for them either. Our State Hospitals—I'm talking now of the Insane Asylums, do not have the facilities or the staff to treat them.

Ought there to be special legislation—if by special legislation you mean ought we to have budget allocation, the answer is yes. The physical facilities I think ought to be arranged by Dr. Perkins but he ought to have the money, and have it quickly. What I'd like to do would be to take some of these kids of nineteen through twenty-five whom I see before me, and instead of sending them to reformatory, I'd send them to

a State Hospital on condition that they remain there until the authorities are satisfied that they can be safely restored to the community. But I can't send them to a hospital in Maryland. I've got to send them either to prison or let them go completely free.

Can the schools do more? Yes, they can and should do more. I only want to take one minute on this subject and say this; I talked with all the school Superintendents of Maryland at private meetings; I talked with Dr. Lemmel and others in connection with the schools. We are coming away from the idea that Mr. Thomsen touched on, I mean the feeling—"don't let's talk about it." It was like sex education, you just learned it only certain ways, you didn't hear it from nice people. Well, I think now we are getting to the point where people are beginning to realize and the O'Connor Committee emphasized the fact that there ought to be real education by competent people on narcotics. Now I'll tell you a strange secret, the law of Maryland requires the schools, *requires the schools* to teach the evils of alcoholism and narcotic addiction. I didn't know it until Dr. Pullen called my attention to it, but that doesn't mean you want to teach it to third graders or eighth graders. What we ought to do to sum up what Mr. Thomsen says is to teach it at the Parent-Teachers Meetings, to the pupils in the upper grades of high schools, we ought to teach it to the *teachers* so they would know what we are talking about. We ought to make the people in the higher echelon in the school department know what we are talking about, because I'm not sure that they quite realize how terrifically serious this problem is.

Q. FROM AUDIENCE: This question is addressed to Judge Sherbow. The point I want to make is this. Why are you disturbed because the drug addicts are moving out among the better class of people? It seems to me it's a community problem.

JUDGE SHERBOW: The gentleman says he is just as much disturbed with the fact that addicts are moving out, that we ought to be as much

disturbed about the fact they are moving into the better economic groups. I agree with him a hundred per cent. I don't think we should recognize any distinction at all whether they are white, colored, rich or poor or whether they come from one section of the city or the other. What I tried to emphasize was the fact that nobody cared much until it got to the point where it hit some people in the better economic groups. Then they began to wake up to the fact that this could happen here. That is the tragedy of it; there wasn't any real interest that I could see until it happened to get to the point where people in the better economic groups were finding that the disease didn't know the boundary of one artificial distinction from another. I agree one hundred per cent with what he says. It's a community problem and it's a terrible problem.

Q. FROM AUDIENCE: Should not the problem of law enforcement in the Counties, at least in the field of narcotics be handled on the State level, particularly since the personnel in some of the County Police Departments are appointed on the basis of political acumen rather than police accomplishment?

JUDGE SHERBOW: The question he asked would take some time to answer, I think this question indicates there is an awareness that there isn't good law enforcement in certain places. To come back to the question, the answer is no, you don't need enforcement on a State level. Who would know better, who should know better who is involved in narcotics and other law violations than the local police, if they are doing their jobs? It's true in all rural sections you don't have intense policing but people in rural areas have a way of letting the police know what is going on. Now, if you are going to delegate this kind of enforcement to the State you will get no enforcement at all. The task is peculiarly local; it was so in Baltimore. We deal with the Federal people by interchange of information; we deal with them by use of certain of their facilities but the job is done locally in Baltimore City by the local police. It could be done in any County by the

County Police. If you haven't got police who will enforce the law put them out and get police who will!

Q. What is the percentage of cure of addicts after treatment? Do you have any data or statistics with respect to that question?

DR. LOWRY: Patients are followed for five years after their discharge from the hospital at Lexington where they are treated for narcotic drug addiction. At the end of five years, it is impossible to obtain information on fifty per cent; thirty-five per cent have relapsed to the use of drugs, and fifteen per cent have not used drugs during the five-year period. Some of those who were counted in the relapse group may not be using drugs at the end of the five-year period but did use them at some time during the five years. Of those that relapse, a number go for one, two or three years before relapse occurs.

Q. What do you think the schools should do about addiction?

DR. LOWRY: My professional qualifications are in the medical treatment of narcotic drug addicts. My personal feeling is that too much public and parent responsibility is often shifted to the schools. This is not a school problem fundamentally, but is a problem of the family and society generally. The school can be looked upon as a medium to reach parents and children. Whether or not education regarding addiction will prevent addiction remains to be determined. Physicians are the best informed group about the addicting properties of drugs. The proportion of drug addicts among physicians is at least ten times that of the general population.

Q. What characteristic seems to be most strongly present in persons predisposed to drug addiction?

DR. LOWRY: There is no single characteristic. In my presentation, I enumerated several types of individuals; 1) the anxious, neurotic, tense individual who is seeking relief from his discomfort; 2) the emotionally immature unstable persons who aren't satisfied with the normal satisfactions of living but who are seeking thrills, pleasure and excitement; 3) the group of predominately anti-social aggressive individuals whose use of drugs is just one facet in the total configuration. All three groups are attempting to escape reality.

Q. MR. WATERS: This is an interesting question that may lead to a difference of opinion between our learned Judge and our Prosecuting Attorney—that is not unusual. I'd like to ask Mr. Sodaro if experience has indicated that the traffic in drugs in Baltimore City is limited to a relatively small group or general throughout the community, and in answering that, Mr. Sodaro, I think it would be of interest to the audience if you would comment upon the personalities and the type of people with whom you have to deal in this particular problem?

MR. SODARO: Well, it has been generally found that the average type of individual whether a juvenile or not, that comes into Criminal Court charged with violation of the Narcotics Law, is the delinquent type of person. Now that doesn't mean that there aren't exceptions. Judge Sherbow a little while ago gave you an example where it can happen in the nicer type of homes. There is always a danger that the disease may infiltrate into the nicer neighborhood and nicer homes. We have had many instances where defendants have come into Court from broken homes. A broken home is always a real source of trouble not only for narcotics but every other type of crime.

THE DIAGNOSIS OF CHRONIC VIRAL HEPATITIS¹

VICTOR M. SBOROV, M.D.²

In the past several years we have become more and more aware of the disease we have now learned to call acute viral hepatitis. During the years of World War II and in the postwar period this condition has been recognized as one of prime importance to the Military. Although percentage-wise the mortality rate from this condition is not high, the prolonged period of hospitalization required in the management of the average case is of serious consequence to the Armed Forces. Physicians in civilian practice also have learned that the diagnosis of hepatitis must be considered in all patients with jaundice and in many patients without jaundice regardless of age, race or sex (1).

Because of its widespread incidence and its economic importance, acute hepatitis has been thoroughly studied by many groups over a period of years. The clinical manifestations and biochemical measurements of the disease have received a great deal of attention; and the usual characteristics of hepatitis have been repeatedly confirmed in many series covering large numbers of cases. We have learned, in general, that the disease may be a benign one, particularly in the younger age groups and that it is self-limited in most cases even without strict management.

In the usual course of events it has been found that the disease may be unusually prolonged by increased physical activity in the early stages (2). The period of jaundice and disability varies from a few days to several months, during which time the patient must be more or less restricted in his activities. An occasional case will have a fulminant course and expire in a period of hours to days. In epidemics involving large numbers of individuals we have learned that there will be one to two deaths per thousand cases of hepatitis (3). An occasional patient, even though well

treated, will have a relapse from his hepatitis which may prolong his period of hospitalization and convalescence by two to three months. This is not common, however, and is rarely encountered in the average practice of medicine. Such an unfortunate event may be inadvertently brought about by the physician who wrongly diagnoses a case of viral hepatitis as one of surgical jaundice and superimposes the trauma of surgery and anesthesia upon an already damaged liver. It is of the utmost importance, therefore, that viral hepatitis be diagnosed early so that harmful maneuvers, such as major surgical procedures may be scrupulously avoided.

It has been suspected for many years that chronic liver disease might result in a certain number of cases with a past history of acute viral hepatitis. The exact incidence of this complication of acute hepatitis is not known, but there seems to be little doubt that chronic liver disease results in a definite number of patients as a sequel to acute hepatitis (4, 5). If one were to follow a known group of patients with acute viral hepatitis, over a period of six to ten years, one might not be impressed with the number of patients who would develop chronic liver disease. A few such studies have been undertaken and it has been found that after a period of five years such cases number less than one per cent of the total. If, on the other hand, one were to see a large number of cases of chronic liver disease one would be distinctly impressed with the number of such cases that appeared to stem from a previous bout of acute viral hepatitis. Thus, in the course of study of acute viral hepatitis, there has been recognized a group of cases with persistent or intermittent symptoms and findings lasting for months or years after a bout of acute hepatitis. The course of such patients is variable; some apparently go on to complete recovery while others manifest a chronic downhill course, ultimately resulting in death. It is, therefore, of some importance in our understanding of liver

¹ Presented before the Annual Meeting of the Baltimore City Medical Society on Friday, December 21, 1951.

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disease to ask ourselves, "what is chronic viral hepatitis?"

If one did not clearly define the term "chronic viral hepatitis" there would be many abuses of this diagnosis. This is true since many of the symptoms present in such patients are admittedly identical with those found in functional gastrointestinal disease. Due to the lack of a specific test for the disease an exact definition of this condition is not possible at the present time. A practical definition to be used as a guide in diagnosis and management should include the following: No patient should be said to have chronic viral hepatitis unless there is a history of acute viral hepatitis. There should be symp-

ways. In the early course of his illness the patient may appear to show a satisfactory recovery manifested by a return to well being and a diminution in the positivity of his liver function tests. In the later course of convalescence, however, recovery is not complete and certain symptoms and findings pointing to hepatic dysfunction persist for a period of months to years. The patient may remain easily fatigued; he may have recurrent gastrointestinal symptoms of nausea and anorexia; he may have a persistently or intermittently abnormal serum bilirubin test, bromsulfalein test, or other tests of abnormal hepatic function. On physical examination there may be found a large liver which is tender to palpation (Tables I and II).

TABLE I

Symptoms and Findings in 48 Cases of Chronic Viral Hepatitis

	PER CENT
Hepatic Enlargement.....	58
R. U. Q. Ache.....	41
Easy Fatigability.....	41
Hepatic Tenderness.....	37
Spider Angiomata.....	31
Intermittent Nausea.....	29
Epigastric Distress.....	27
Nervousness.....	22
Intermittent Malaise.....	14
Intermittent Diarrhea.....	14
Palmar Erythema.....	14
Fatty Food Dyscrasia.....	10
Palpable Spleen.....	10

toms, physical findings or laboratory findings of hepatic disease which persist or recur six months or longer after a bout of acute hepatitis; and a biopsy of the liver should show abnormal liver histology (6). Although this definition may exclude a hypothetical group of patients with functional liver cell disease, it only includes those patients who have objective evidence of liver involvement which follow chronologically a bout of acute viral hepatitis.

In the past three years we have had the opportunity to study carefully 48 patients who meet these criteria. In the reconstruction of the chronology of this disease, we have found that the manifestations usually appear in one of two

TABLE II

Relative Frequency of Positive Liver Function Tests in 48 Cases of Chronic Viral Hepatitis

	PER CENT
Urine Urobilinogen.....	77
Bromsulfalein.....	73
Zinc Turbidity.....	68
Thymol Turbidity.....	38
Total Serum Bilirubin.....	29
Thymol Flocculation.....	27
One Minute Serum Bilirubin.....	23
Cephalin Cholesterol Flocculation.....	15
Urine Bilirubin.....	6

The second group, which corresponds to so-called "latent hepatitis" appears not to differ in any way whatever from the patient with the usual course of acute viral hepatitis. That is, after the first week or two of symptoms there is a definite and progressive return of well being with diminution to normal of liver function tests, and disappearance of the large tender liver. The total duration of the course usually does not exceed three months. After a varying period of months or years following return to full activity, however, the patient may begin again to notice the gradual onset of symptoms related to his liver. These symptoms may consist of easy fatigability and soreness in the right upper quadrant. Upon examination of such a patient there

may be found an enlarged tender liver with liver functional abnormalities as demonstrated in the laboratory.

Because chronic viral hepatitis has not been uniformly recognized as an entity, many such cases are misdiagnosed as psychoneurosis or as functional gastrointestinal diseases. With ordinary examination these patients frequently fail to show objective evidences of hepatic disease and it becomes difficult to relate symptoms they may have, to a previous bout of acute viral hepatitis which may have occurred months or even years in the past. In an average practice of medicine, where not many cases of acute viral hepatitis are seen, this chronic manifestation of acute liver disease may never be encountered. It is in fact, because the total mortality rate and total residual rate has been so low, that the average physician seldom sees either and considers hepatitis to be a completely benign disease unworthy of strict management. This is, however, not the case. It is important to be aware of the possibility of chronic liver disease, not only in the patient who manifests the symptoms and findings, but also in the early treatment of viral hepatitis so that proper precautions can be taken to ensure a minimum period of disability.

Such reports as are available of chronic liver disease following acute viral hepatitis have been gained from the Armed Forces where large numbers of cases of the acute disease have been seen. In 1944, a group of studies was reported by Caravati who referred to this picture as "the post-hepatitis syndrome" (7). The outstanding characteristics present in these patients were fatigue, right upper quadrant discomfort, fatty food intolerance, malnutrition and emotional instability. This picture was seen to last for weeks or months after the onset of acute viral hepatitis. Caravati recognized the relationship of this syndrome to acute hepatitis, but believed it was not related to organic liver disease. All of his patients had normal liver function tests and negative physical findings. Histologic studies were not made in these patients.

In 1946, Sherlock and Walshe reported another group of the so-called "post-hepatitis syndrome" among English soldiers (8). Here again, the manifestations were considered to be psychoneurotic in origin and not related to organic liver disease. In these patients there were also noted structural abnormalities of the liver upon biopsy and some borderline liver function tests. It was believed by the authors that the main motivation in these patients as far as their complaints were concerned was to be discharged from the Army. It was thought that patients of this type who were hospitalized as a group on a single ward exchanged complaints so that a similarity in wording of histories often was noted. All were anxious to display evidences of their hepatic disease. Many of this group were noted to have a palpable liver and spleen, but this was discounted somewhat by the authors who felt these patients were able to push down their livers and spleens merely by deep respiration rendering these organs palpable. Accordingly, the recommendation was made that such patients be dispersed about the hospital and not be allowed to compare symptoms so far as their liver disease was concerned.

Subsequent reports by several investigators in this country and abroad with the use of more refined liver function tests, and with the wider use of the liver biopsy, have confirmed the fact that the residuals of viral hepatitis previously described in patients at varying periods of time following acute hepatitis, are probably related to residual organic liver disease (9, 10). It is believed that most of these symptoms are not psychoneurotic. Although there may be a neurotic overlay in many of these patients because of the prolonged hospitalization, or because of the underlying personality defects, these may be true manifestations of chronic liver disease.

In considering the criteria for diagnosis of chronic viral hepatitis an unequivocal history of acute hepatitis should be obtained; this is necessary because the other enumerated criteria may

be present due to other forms of chronic liver disease unrelated to the virus of hepatitis. It is also believed that this history of acute hepatitis should include jaundice. There is little question that hepatitis may occur with subclinical or absent jaundice and that this condition may go on to a chronic form of the disease. A retrospec-

cedent jaundice by means of other liver function tests and possibly by means of a liver biopsy. In the absence of this close observation and complete diagnostic study, however, the diagnosis cannot be proven.

Under ordinary circumstances the symptoms, clinical findings and laboratory findings of

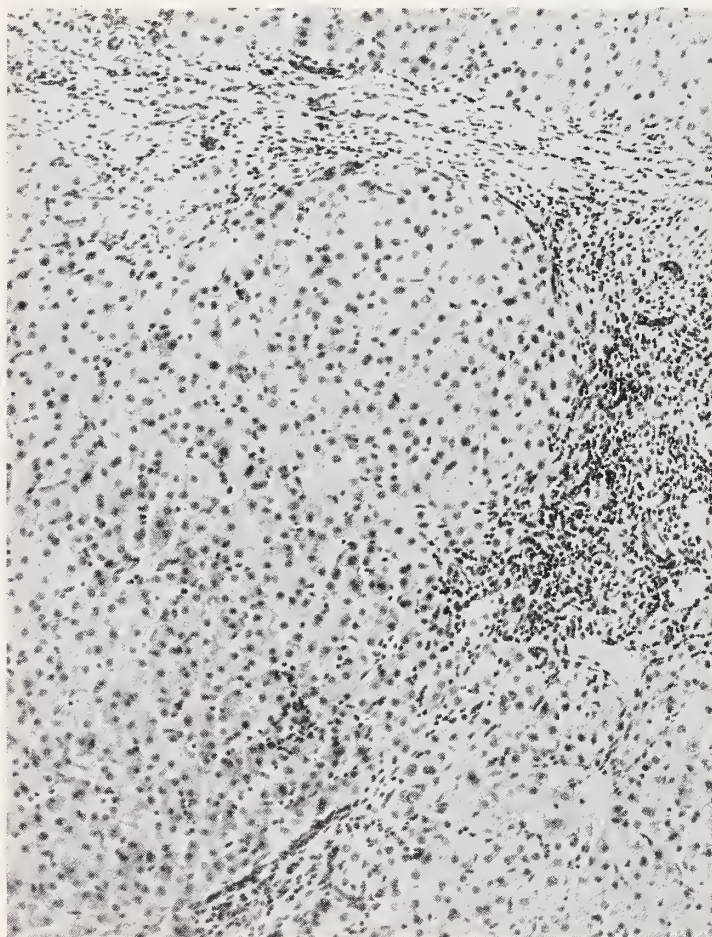


FIG. 1. Chronic viral hepatitis. Forty-four year old patient who first developed hepatitis eight years prior to present biopsy. Three recurrences with jaundice since. Symptoms of intermittent fatigue and epigastric distress. All liver function tests negative except for bromsulfalein retention of 15%. Section shows widening of portal space and increase of mononuclear infiltrate. Portal scarring is present with extension into the surrounding parenchyma. Increase in the number of bile ducts is seen. Foci of necrosis are noted in liver lobules. Liver cells show many binucleate forms. $\times 110$.

tive diagnosis of acute hepatitis without jaundice, however, would be difficult, if not impossible, to establish. If, on the other hand, a patient were observed by the same physician over a period of time, during which there was a transition from acute hepatitis to the chronic state, I believe it would be possible to establish the diagnosis of chronic hepatitis even without ante-

hepatic disease, which persist or recur six months or longer after the bout of acute hepatitis, are really the only signs we have of the persistence of the disease. Unless the course of the illness is followed from its very inception, it is not likely that laboratory tests will be performed in a routine fashion throughout the entire course. If symptoms persist however, the syndrome is

called to the attention of the physician, who then carries out a physical examination and certain laboratory tests to establish a diagnosis. Even in the presence of objective findings in the clinical and laboratory examinations, it is believed that a liver biopsy is mandatory to establish the diagnosis of "chronic viral hepatitis" and to determine the stage of the disease. We have as yet not encountered a patient with positive liver function tests, with or without symptoms of chronic liver disease, who did not have abnormalities as demonstrated from a biopsy of the liver. The converse is not true, that is, *normal liver function tests may not mean a normal liver*.

The pathology encountered in the livers of patients with chronic viral hepatitis is widely variable (6). There may be only minimal changes consisting of binucleation of the liver cells and evidences of regeneration with small foci of mononuclear cells indicating necrosis. Bile duct proliferation is usually prominent and there are varying degrees of portal scarring present (Fig. 1). It is believed that without the other criteria for the diagnosis of chronic viral hepatitis the distinction of this condition cannot be made from the liver biopsy alone. Since the histologic findings noted in such patients are not discriminatory as far as other forms of liver disease are concerned, it is recognized that the diagnosis "chronic viral hepatitis" is *etiologic* and may by definition include all phases of morphologic changes in the liver from "mild inflammatory changes" to "advanced scarring." Thus, what we now call cirrhosis of the liver could be included as an end stage of chronic viral hepatitis.

A great deal yet remains to be learned about this chronic phase of viral hepatitis. We are not at all confident that the predisposing factors for the development of chronic viral hepatitis are limited to those already enumerated, namely: older age at onset, use of alcohol, intercurrent infections, and incomplete therapy at the outset.

It seems highly likely at the moment, though not yet proven, that there may be continued viral activity in these cases responsible for their clinical, biochemical, and histological manifestations of disease. Experiments are now in progress where the sera from patients with chronic viral hepatitis are injected into human volunteers to determine if the infectious agent remains active in these cases.

We are as yet in the very early stages of our study of this phase of liver disease. This report merely is intended to define the entity of chronic viral hepatitis so that in the future the discussion of this problem can proceed from a common starting point. Until there is uniform agreement concerning the existence of this stage of hepatitis and the criteria for its diagnosis, we cannot proceed with the important problems of pathogenesis, treatment and ultimate prognosis of this disease.

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Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.,

Journal Representative

On December 7, 1951, the following officers were elected: *President*, Emmett L. Jones, Jr.; *Vice-President*, W. R. Hodges, Jr.; *Secretary*, R. Rhett Rathbone; *Treasurer*, Leland B. Ranson; *Delegates*, John K. Rozum; James T. Johnson, Jr.; *Alternate Delegates*, Hilda Jane Walters; Bendeict Skitarelic.

The Allegany-Garrett County Medical Society has extended an invitation to the Medical and Chirurgical Faculty to hold its Semi-annual Meeting in Cumberland in 1953. Clinics would be held in the local hospitals by representatives from the University of Maryland Hospital and The Johns Hopkins Hospital.

The Council and House of Delegates of the Medical and Chirurgical Faculty will be informed by the Secretary of this invitation.

Dr. Edward Leach, of Baltimore, discussed "Heart Diseases in Pregnancy," at a meeting of the Society, which was held January 18, at the Cumberland Country Club.

In February, Dr. Edgar W. Davis, of Washington, D. C., will discuss "Newer Developments in Chest Surgery," with particular emphasis on earlier diagnosis.

Dr. C. C. Zimmermann, Cumberland, has just returned from the Bahamas.

Dr. James E. McLean assumed his new position as County Physician, January 1, succeeding Dr. Arthur Jones, also of Cumberland. Dr. Jones has returned to general practice.

Dr. Emmett L. Jones attended the General Meeting of the Pan American Association of Ophthalmology in Mexico City in early January.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.,

Journal Representative

At a recent meeting of the Anne Arundel County Medical Society, the following new members were

elected: J. Howard Beard, A. R. Sosnowski, G. Douglas Trettin, M. K. Willoughby.

Dr. William N. Thomas was recently made head of the X-ray Department of the Anne Arundel General Hospital. Dr. Thomas comes to Annapolis well qualified. He completed a Fellowship with the Radiological Clinic of Doctors Groover, Christie, and Mearitt in Washington, D. C., and also served a year each in the X-ray Departments of Emergency, Doctors, and Garfield Hospitals in Washington. In December, 1950, he was certified by the American Board of Radiology.

BALTIMORE CITY MEDICAL SOCIETY

SAMUEL McLANAHAN, M.D., *President*

The new officers look forward to 1952, as a year of further expansion of the activities of the Society, and as a year in which an increasing number of individuals will be called upon to participate in the various opportunities and responsibilities which the organization presents. The thanks and appreciation of the Society go especially to Dr. Lewis P. Gundry, the retiring secretary who has served us so well for the past five years. The total membership of the Baltimore City Medical Society now stands at approximately 1,425. From this large number, the various committees have been appointed, totaling approximately 85 members. These committees are, of course, distinct from the committees of the Faculty, and these members are in addition to those already elected to serve as delegates to the State Society.

The Program Committee under the chairmanship of Dr. Wetherbee Fort is continuing its fine work of last year, with further excellent clinical sessions being planned for this spring and next fall. The programs this fall and winter have been well attended and have drawn praise from all quarters. Plans are already under way to make the facilities of Osler Hall more comfortable as well as more efficient. Financed jointly by the Faculty and by this Society a ventilating system will be installed and a new public address system with wire recorder, a new projector and a new screen will be placed in the Hall. The wire recorder will make it possible to preserve the addresses

and discussions for subsequent publication in this JOURNAL.

Members can be of real help by encouraging membership on the part of all eligible physicians in the community who are not already enrolled, by attend-

ing meetings of the Society and its special Sections and by giving constructive suggestions to the officers of the Society toward any means by which its service to the profession and to the community can be improved.

Meetings

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall

SAMUEL McLANAHAN, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*

J. ALBERT CHATARD, M.D., *Treasurer*

Friday, March 21, 1952, 8:30 p.m.

**SYMPOSIUM ON THE DIAGNOSTIC PROBLEMS ASSOCIATED WITH
FLUID AND ELECTROLYTE IMBALANCE**

8:30 p.m.

Electrolyte and Fluid Problems in Surgical Patients. DAVID M. HUME, M.D., Junior Assistant in Surgery, Peter Bent Brigham Hospital; Instructor in Surgery and Director of Surgical Research, Harvard Medical School, Boston, Massachusetts. (By invitation.)

9:15 p.m.

Electrolyte Disturbances in Congestive Heart Failure. WILLIAM B. SCHWARTZ, JR., M.D., Assistant Professor of Medicine, Tufts College Medical School; Assistant Physician, New England Center Hospital, Boston, Massachusetts. (By invitation.)

10:00 p.m.

Question period.

ANESTHESIOLOGY SECTION

OTTO C. PHILLIPS, M.D., *Chairman* EDWARD I. LEDERMAN, M.D., *Secretary*

Monday, March 3, 1952, 8:30 p.m.

Fire and Explosion Hazards in Hospitals and Their Prevention. Demonstration Lecture. (Lantern slides.) GEORGE J. THOMAS, M.D., Associate Professor of Surgical Anesthesiology and Chairman of the Section on Anesthesiology, University of Pittsburgh School of Medicine. (By invitation.)

SECTION ON DISEASES OF THE CHEST

MOSES S. SHILING, M.D., *Chairman*

EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, March 5, 1952, 8:00 p.m.

A Study of Accuracy of Chest Film Interpretation. (Illustrated.) DAVID M. GOULD, M.D.

OPHTHALMOLOGICAL SECTION

ABRAHAM KREMEN, M.D., *Chairman*

ANGUS L. MACLEAN, M.D., *Secretary*

JOINT MEETING WITH THE OPHTHALMOLOGICAL SECTION OF THE
DISTRICT OF COLUMBIA MEDICAL SOCIETY

Thursday, March 6, 1952

Dinner 6:30 p.m., Scientific Meeting 8:00 p.m.

Stafford Hotel

Sensitization and Desensitization. RONALD M. WOOD, B.Sc., Mellon Fellow in Ophthalmology, The Johns Hopkins University School of Medicine. (By invitation.)

Management of Retinal Detachment. CHARLES L. SCHEPENS, M.D., Boston, Massachusetts. (By invitation.)

ORTHOPAEDIC SECTION

JESSE N. BORDEN, M.D., *Chairman*

EDMOND J. McDONNELL, M.D., *Secretary*

JOINT MEETING WITH THE ORTHOPAEDIC SECTION OF THE
PHILADELPHIA MEDICAL SOCIETY

Friday, March 7, 1952

Scientific Meeting 3:00 p.m., Dinner 5:30 p.m.

Stafford Hotel, Baltimore

1. Central Dislocations of the Hip. GEORGE O. EATON, M.D.
 2. Congenital Anomalies of the Spine. JAMES P. MILLER, M.D.
 3. Developmental Aspects of the Spine. W. RICHARD FERGUSON, M.D.
 4. Discograms and Diagnosis of Herniated Discs. JOHN J. DAVIES, M.D.
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OTOLARYNGOLOGICAL SECTION

THOMAS R. O'ROURK, M.D., *Chairman*

J. JULIAN CHISOLM, M.D., *Secretary*

Tuesday, March 11, 1952

Dinner Meeting, 6:30 p.m., Johns Hopkins Club, Homewood

Kodachrome Clinic of the Pathology of Bronchial Obstruction. PAUL H. HOLINGER, M.D., Associate Professor of Otolaryngology, University of Illinois School of Medicine, Chicago, Illinois. (By invitation.)

PEDIATRIC SECTIONWILSON GRUBB, M.D., *Chairman*GIBSON J. WELLS, M.D., *Secretary**Tuesday, March 11, 1952, 8:30 p.m.*

Program to be announced.

NEUROPSYCHIATRIC SECTIONSAMUEL NOVEY, M.D., *Chairman**Thursday, March 13, 1952, 8:30 p.m.*Cultural Anthropology. (*Title to be announced.*) DAVID ABERLE, Ph.D., The Johns Hopkins University.

PATHOLOGY SECTIONWILLIAM V. LOVITT, JR., M.D., *Chairman**Tuesday, March 11, 1952, 7:30 p.m.**Mercy Hospital*

Program to be announced.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

RICHARD W. TELINDE, M.D., *Chairman*BEVERLEY C. COMPTON, M.D., *Secretary**Thursday, March 20, 1952**5:00 to 6:00 p.m.*

DERMATOLOGICAL SECTIONISRAEL ZELIGMAN, M.D., *Chairman*RAYMOND C. V. ROBINSON, M.D., *Secretary**Monday, March 24, 1952, 8:30 p.m.*

1. Treatment of Superficial Angiomas. GRANT E. WARD, M.D.
Discussion opened by FRANCIS A. ELLIS, M.D.
2. Chloromycetin in the Treatment of Dermatoses. (Illustrated.) HARRY M. ROBINSON, JR., M.D.
Discussion opened by ROBERT T. PARKER, M.D.

MATERNAL MORTALITY MEETING*Thursday, March 27, 1952, 4:00 p.m.*

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

RADIOLOGICAL SECTION

J. HOWARD FRANZ, M.D., *Chairman*

RICHARD B. HANCHETT, M.D., *Secretary*

Due to the meeting of the Eastern Conference of Radiology, March 28 and 29, 1952, at the Hotel Statler, New York City, the regular March meeting of the Radiological Section will not be held.

SYMPOSIUM ON MEDICAL ASPECTS RELATING TO EUTHANASIA

Under the Auspices of the Medicolegal Committee

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, March 28, 1952, 8:00 p.m.

PANEL DISCUSSION

MR. JOHN S. STANLEY, *Moderator*

President, Maryland State Bar Association

1. Historical Development of Euthanasia. GEORGE BOAS, Ph.D., LL.D., Professor of the History of Philosophy, The Johns Hopkins University.
 2. Legal Aspects Relating to Euthanasia. CHARLES E. ORTH, Esq., Formerly Assistant State's Attorney of Baltimore City.
 3. Medical Aspects Relating to Euthanasia. LOUIS KRAUSE, M.D., Professor of Clinical Medicine, University of Maryland School of Medicine.
- Questions from the floor.

CALVERT COUNTY MEDICAL SOCIETY

PAGE C. JETT, M.D.,
Journal Representative

At a meeting of the Calvert County Medical Society held January 8th, the following officers were elected for 1952: *President*, Roberto de Villarreal; *President-Elect*, Earl S. Coster; *Secretary-Treasurer*, Page C. Jett; *Delegate*, Hugh W. Ward; *Alternate Delegate*, George J. Weems.

The physicians in Calvert County are looking forward to the completion of the new \$667,000 twenty-seven bed hospital which is being built on a site about a mile north of Prince Frederick. There has been a great need for adequate hospital facilities, and the Hill-Burton Fund with rural participation is making it possible to achieve this end.

The doctors are also looking forward to a reorganization of the staff so that better consultation services can be provided for this community.

CAROLINE COUNTY MEDICAL SOCIETY

ROBERT WRIGHT, M.D.,
Journal Representative

The following officers of the Caroline County Medical Society have been elected for 1952: *President*, James F. Wright; *Vice-President*, Charles H. Winnacott; *Secretary-Treasurer and Journal Representative*, Robert Wright; *Delegate*, Harold B. Plummer; *Alternate*, F. M. Anderson.

CARROLL COUNTY MEDICAL SOCIETY

M. C. PORTERFIELD, M.D.,
Journal Representative

On December 19, 1951, the Carroll County Medical Society elected the following officers: *President*, W. C. Jennette; *Vice-President*, Merritt Robertson; *Secretary-Treasurer*, Wilbur H. Foard; *Delegate*, M.

C. Porterfield; *Alternate Delegate*, R. E. Gardner, *Board of Censors*, R. S. McVaugh, Merritt Robertson, and James T. Marsh; *Medical Aid Advisory Committee*, Julius Chepko, M. C. Porterfield, and R. S. McVaugh.

On February 20, 1952, a meeting was held at the Hoffman Inn, Westminster. Dr. Paul Harper, Professor of Public Health Administration (Maternal and Child Health), The Johns Hopkins School of Hygiene and Public Health, will discuss a new state-wide study on premature infants.

The construction of the new Carroll County War Memorial Medical Center is about half completed. It is located on the outskirts of Westminster. The new center is to serve as quarters for the County Health Department and will also provide space for various clinics.

NEW HEALTH OFFICER ASSUMES DUTIES

Dr. Neil Scott Gordon has been appointed Deputy State Health Officer of Carroll County, effective January 1, 1952. He is now directing the health program in this county.

Dr. Gordon, who is a Canadian, received the degree of Doctor of Medicine from Queen's University, Kingston, in 1940. He received a Diploma in Public Health from the University of Toronto in 1949.

The newly appointed health officer has had considerable hospital and public health experience, in addition to having served as a medical officer in the Royal Canadian Air Force during World War II. His most recent position was that of full-time District Medical Officer in the City of Toronto Department of Health.

DORCHESTER COUNTY MEDICAL SOCIETY

WALTER B. JOHNSON, M.D.,
Journal Representative

At the December meeting of the Dorchester County Medical Society, the following officers were elected for 1952: *President*, Alfred R. Maryanov; *Vice-President*, William H. Hanks; *Secretary-Treasurer*, Walter B. Johnson; *Delegate*, Eldridge H. Wolff; *Alternate Delegate*, John Mace, Jr.; *Board of Censors*, Lawrence Maryanov.

The Dorchester County Medical Society meets on the third Wednesday of each month. Prior to the Fall of 1950, meetings had been held in the Health Department office or the recreation room of the Cambridge-Hospital Nurses' Home. Monthly meetings are now being held at the homes of the various members, and following scientific and business sessions, refreshments are served. The attendance since this latter plan has been adopted, has increased from a former average of 25 or 30 per cent to an average of 80 or 90 per cent for each meeting.

During the past year, we have had five speakers from Baltimore, and have shown two films on medical topics.

FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D., *Secretary*

At a recent meeting of the Frederick County Medical Society, the following officers were elected for 1952: *President*, Charles H. Conley, Jr., *First Vice-President*, James E. Stoner, Jr.; *Second Vice-President*, B. O. Thomas, Jr.; *Treasurer*, John McC. Culler; *Secretary*, Jesse S. Fifer; *Delegate*, Jacob Elmer Harp; *Alternate Delegate*, Norvell Belt.

A unique organization has sprung up in Frederick County which is believed to be entirely original and which will serve many good purposes in the community.

In early spring, 1951, the idea of Hospital Aid, Inc., was conceived, nurtured, firmly established and then incorporated by civic minded professional, industrial, agricultural and commercial representatives.

Approximately sixty of these public spirited citizens became the directorate of this nonprofit organization, adopting the following objectives: The aim of Hospital Aid, Inc., is to help directly those confronted with illness or accident which necessitates hospitalization when insufficient funds are available to meet unexpected hospital bills, Hospital Aid, Inc., after proper investigation of requests for assistance, will pay the hospital bill. The loan can be repaid without interest, at a rate convenient for the borrower, as little as a dollar a week.

How are funds obtained and used? Hospital Aid's sole source of income is dues collected from its voluntary membership. As loans are repaid, the money goes back to the fund to be loaned out again. To

date, approximately four hundred twenty persons have joined Hospital Aid by paying yearly dues in one of the following amounts: \$6.00, \$12.00, \$25.00, \$50.00, \$100.00, or by obtaining a life membership for \$1,000.00. All are eligible for membership. Membership may be obtained by selecting the type of dues desired and mailing the amount to Hospital Aid, Inc. P.O.Box #111, Frederick, Maryland.

In addition to helping those who temporarily can't help themselves, Hospital Aid may financially assist the Frederick Memorial Hospital. This hospital is looked upon as the natural hospitalization center for Frederick and adjacent counties.

In commenting upon Hospital Aid, Inc., one of its directors said: "The numerous letters we have received from people in all walks of life have been very encouraging. They have made the directors determined to help build Hospital Aid, Inc., into a strong institution. Of those who have participated in our program, we would like to thank personally, but our thanks are small compared to the gratitude of those who, through your efforts, will find it possible, now and in the future, to have aid when it is needed."

The Frederick County Medical Society has sent this information not only because of its news value, but also that other counties may be interested and set up such a project.

HOWARD COUNTY MEDICAL SOCIETY

THEODORE R. SHROP, M.D.,
Journal Representative

On November 30, 1951, the following officers of the Howard County Medical Society were elected for 1952: *President*, George E. Burgtorf, Jr.; *Vice-President*, George E. Groleau; *Secretary-Treasurer*, Theodore R. Shrop; *Delegate*, Frank E. Shipley; *Alternate*, B. Bruce Brumbaugh.

MONTGOMERY COUNTY MEDICAL SOCIETY

L. MARSHALL CUVILLIER, JR., M.D.,
Journal Representative

The Montgomery County Medical Society started the New Year with a meeting on January 15th, at Olney Inn, Olney, Maryland, at which time the new

officers presided. Officers for 1952 are: *President*, Frank A. Zack; *Vice-President*, William S. Murphy; *Treasurer*, Charles H. Ligon; *Secretary*, L. Marshall Cuvillier, Jr.

Dinner meetings will be held the third Tuesday of each month, September through June. The dinner is at 7:00 p.m., followed by the Scientific meeting at 8:00 p.m. After the scientific session, a business meeting of the Montgomery County Medical Society is conducted.

The Society extends an invitation to all visiting physicians who may wish to attend.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

SAMUEL J. N. SUGAR, M.D.,
Journal Representative

The Prince George's County Medical Society have elected the following officers for 1952: *President*, Samuel J. N. Sugar; *Vice-President*, John M. Warren; *Corresponding Secretary*, Benjamin Miller; *Recording Secretary*, Julius Kauffman; *Treasurer*, William B. Hagan; *Delegates*, Waldo B. Moyers and Wolcott L. Etienne; *Alternate Delegates*, William Brainin and James G. Sasscer; *Censor*, Louis M. Jimal.

The Scientific Program for the February meeting of the Society consisted of a discussion of "Management of Cleft Palate" by Dr. Robert E. Moran, of Washington, D. C.

Dr. Benjamin Miller recently returned from Florida where he was convalescing from pneumonia. He states that barracuda are plentiful.

Plans for a Golf Tournament this Spring are being considered by Dr. Fred Musser.

QUEEN ANNE'S COUNTY MEDICAL SOCIETY

WILLIAM G. MARTIN, M.D.,
Journal Representative

Queen Anne's County Medical Society held its last meeting on October 21, 1951, at which time it elected the following officers for 1952: *President*, W. H. Fisher; *Vice-President*, H. F. McPherson; *Secretary-Treasurer*, C. Rodney Layton; *Delegate*, Norman S. Dudley; *Alternate*, Irvin G. Hoyt.

The members of the Society have approved the

establishment of an arthritic clinic in Queen Anne's County. It has also approved a resolution against socialized medicine.

It was agreed, to hold luncheon meetings at tri-monthly intervals in the third week of designated months.

ST. MARY'S COUNTY MEDICAL SOCIETY

J. ROY GUYTHER, M.D.,
Journal Representative

The annual meeting of the Southern Maryland Medical Society was held in Leonardtown, November 15th. There were 40 physicians present, representing Charles, Calvert, Prince George's and St. Mary's Counties.

Guest speakers were Dr. Brian B. Blades, Professor of Surgery, George Washington School of Medicine, who spoke on "Bronchogenic Carcinoma"; Dr. John E. Savage, Associate Professor of Obstetrics, University of Maryland School of Medicine, who spoke on "The Management of the Third Stage of Labor." Dr. Walter D. Wise, President of the Medical and Chirurgical Faculty, also gave a short talk on "Committees of the State Medical Society."

Dr. Robert S. McCeney of Laurel was elected president for the year of 1952 to replace Dr. J. Roy Guyther of St. Mary's County who held that position in 1951.

TALBOT COUNTY MEDICAL SOCIETY

LOUIS S. WELTY, M.D.,
Journal Representative

The Talbot County Medical Society officers for 1952 are as follows: *President*, Martin F. Buell; *1st Vice-President*, J. E. Baybutt; *2nd Vice President*, Kurt Lederer; *Secretary-Treasurer*, Louis S. Welty; *Delegate*, J. Thompson B. Ambler; *Alternate*, William S. Seymour; *Censor*, W. N. Palmer.

Dr. A. McC. Stevens, of Easton, was elected an honorary member.

Doctors W. D. Noble, J. T. Baker and Louis S. Welty were appointed a Medical Economics Com-

mittee to cooperate with the Medical and Chirurgical Faculty Committee to Study Certain Phases of Medical Economics. It is the belief of the Talbot County Medical Economics Committee that the first thing urgently needed is for Dr. Moyer's Committee at the State level to set forth a statement of its aims and objects in clear, logical and lucid language.

WASHINGTON COUNTY MEDICAL SOCIETY

W. D. CAMPBELL, M.D.,
Journal Representative

On October 18, 1951, the following officers were elected by the Washington County Medical Society for a period of one year: *President*, Philip J. Hirshman; *Vice-President*, Jack H. Beachley; *Secretary-Treasurer*, Ernest F. Poole; *Delegate*, Robert V. Campbell; *Alternate*, William T. Layman; *Board of Censors*, Samuel R. Wells.

WICOMICO COUNTY MEDICAL SOCIETY

ROBERT LEE BAKER, M.D.,
Journal Representative

The Wicomico County Medical Society, at its December meeting, elected the following officers for 1952: *President*, I. Rivers Hanson; *Vice-President*, Jesse R. Wanner; *Secretary-Treasurer*, Robert Lee Baker; *Delegate*, Osborne D. Christensen; *Alternate Delegate*, William D. Gray.

Dr. J. Edmund Bradley, of Baltimore, was the principal speaker at this meeting. His topic, "Croup" was most timely, and he discussed in detail the types of croup and their treatment.

On January 14th, Dr. Donald H. Stubbs, President of the Southern Anesthesiologists, spoke on "The Anesthesiologist in General Therapy."

The Wicomico County Medical Society was well represented at the Sugar Bowl game in New Orleans, on January 1st. Dr. and Mrs. William B. Long, Dr. and Mrs. I. Rivers Hanson and Dr. and Mrs. Philip A. Insley proceeded via the special train for Maryland rooters.

Library

WHO'S WHO ON LIBRARY COMMITTEE

WHARTON, LAWRENCE RICHARDSON, Surgeon and Gynecologist; received B.Ph. 1907, Hiram College; M.D., Johns Hopkins University Medical School; Associate in Gynecology, Johns Hopkins University; Assistant Attending Gynecologist, Johns Hopkins Hospital; President of Baltimore City Medical Society, 1942; Past Chairman of Section of Gynecology of Southern Medical Association; Past President of Baltimore Gynecological and Obstetrical Society, 1942; Member of American Urology Association; Southern Surgical Association; American Board of Gynecology and Obstetrics (Diplomate); Southern Medical Association; Member of Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1930; author of *Gynecology*, 1947; in addition to numerous articles and monographs on clinical and research problems in Gynecology and Female Urology.

PEARRE, ALBERT AUSTIN, Specialist in Internal Medicine; educated at University of Virginia, B.S. 1920, M.D. 1922; Director of Clinical Laboratory of Frederick City Hospital since 1925; Physician to Hood College since 1925; Physician to Maryland State School for Deaf since 1942; Member of Frederick County Medical Society (President, 1943-44); Southern Medical Society; American College of Physicians; American Medical Association; Medical and Chirurgical Faculty of Maryland (Vice-President, 1943; President, 1950); elected member of the Medical and Chirurgical Faculty Library Committee, 1952-56.

KING, JOHN THEODORE, Physician-in-Chief, Baltimore City Hospitals, 1939-46; Associate Professor of Medicine, Johns Hopkins University; educated at Princeton University, A.B. 1910; Johns Hopkins University Medical School, M.D. 1914; Member, Tuberculosis and Heart Boards, 1917-19; Visiting Physician, 1938-, Johns Hopkins Hospital; Member of Baltimore City Medical Society; Southern Medical

Association; American Medical Association; American Society for Clinical Investigation; American Clinical and Climatological Association; Association of American Physicians; American College of Physicians; Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1949; Chief of Medical Service, Walter Reed General Hospital, Washington, D. C., 1942-45; author of numerous technical works.

WOLMAN, SAMUEL, Physician; educated at Baltimore City College, 1899, and Johns Hopkins University, A.B. 1902, and M.D. 1906; Associate in Medicine at Johns Hopkins University; Consulting Physician to Sinai Hospital and Mt. Pleasant Sanatorium; Visiting Physician to Johns Hopkins Hospital; Consultant to Commissioner of Health of Baltimore; Past President of Maryland Tuberculosis Association and Director of National Tuberculosis Association; Member of American Medical Association; Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1930.

KRAUSE, LOUIS A. M., Graduate of the University of Maryland School of Medicine; Diplomate of the American Board of Internal Medicine; Ex-Governor of the American College of Physicians; Member of the Advisory Board of the Faculty of the University of Maryland School of Medicine; Professor of Clinical Medicine; Member of the American Medical Association; Southern Medical Association; Fellow in the American College of Physicians; Member of the Medical and Chirurgical Faculty of Maryland; served on the Library Committee of the Medical and Chirurgical Faculty of Maryland since 1950; President of the Baltimore City Medical Society, 1951; Member of School of Oriental Research, Jerusalem, Israel.

WHO'S WHO ON THE FINNEY FUND COMMITTEE

FINNEY, JOHN MILLER TRAIN, JR., Surgeon; educated at Princeton, B.S. 1915; Johns Hopkins, M.D.

1919; Member of the Staff Executive Committee of Union Memorial Hospital; Instructor and Associate in Surgery, Johns Hopkins Medical School; President, Baltimore Council, Boy Scouts of America, 1943; Executive Committee, Baltimore Chapter of the American Red Cross; President, Baltimore City Medical Society, 1950; Member of American Medical Association, Southern Medical Association, American College of Surgeons, Southern Surgical Association, American Surgical Association, Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1942; President, Eastern Surgical Society, 1934-35; President, Southern Society of Clinical Surgeons, 1936-37 and Chairman of Surgical Section, Southern Medical Association, 1940; author of numerous professional monographs and addresses.

HAMBURGER, LOUIS PHILIP, Medical Consultant; educated at Maryland College of Pharmacy, 1888-89; Johns Hopkins, A.B. 1893, M.D. 1897; University of Berlin, 1898-99; President of Baltimore City Medical Society, 1931-32; President of Johns Hopkins Medical Society; Consultant to Baltimore City Health Department, 1937-; served as Member of Committee of Revision of Pharmacopeia of U. S. A. (X Edition); Member of American Medical Association; American College of Physicians; American Association of University Professors; American Association for Advancement of Science; Medical Library Association; Southern Medical Association; Association for Prevention of Tuberculosis; Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1937; author of numerous articles on internal medicine, which have been published in various medical journals.

McLANAHAN, SAMUEL, Surgeon; educated at Princeton University, A.B. 1923; Johns Hopkins University, M.D. 1927; Assistant Professor of Surgery, Johns Hopkins Medical School; Past Member of Board of Directors of Associated Hospital Service of Baltimore, Inc.; Diplomate of American Board of Surgery; Fellow of American College of Surgeons; Member of Baltimore City Medical Society (President, 1952); American Medical Association; Southern Medical Association; Southern Surgical Club; Southern Surgical Association; Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1948; author of articles on General Surgery in current medical journals.

THOMAS, HENRY MALCOLM, JR., Internal Medicine, B.S., M.D.; Johns Hopkins University School of Medicine, 1916; Associate Professor of Medicine, Johns Hopkins University School of Medicine; Diplomate, American Board of Internal Medicine; Fellow of American College of Physicians; Member of Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1950.

STONE, DOUGLAS H., A.B., M.D.; Harvard, 1937; Instructor in Surgery, Johns Hopkins; Surgeon, Out-Patient Department, Johns Hopkins Hospital; Visiting Staff, Surgery, Church Home and Hospital and Union Memorial Hospitals; Associate Staff, Surgery, Hospital for the Women of Maryland; Courtesy Staff, Surgery, St. Agnes and St. Joseph's Hospitals; Consulting Staff, Surgery, Provident Hospital and Free Dispensary; Member of Medical and Chirurgical Faculty of Maryland; served on the Finney Fund Committee of the Medical and Chirurgical Faculty of Maryland since 1949.

Civil Defense

CASUALTY CLEARING STATIONS

BRIGADIER GENERAL R. P. WILLIAMS¹

On assuming duty as Maryland's Chief of Medical Services for Civil Defense, I find that the State has made very commendable progress in its preparation. The State has been very well organized and broad plans and policies have been issued which, when carried into effect, will give Maryland adequate medical service to meet its obligation in case of enemy attack. However, the implementation of these plans has just begun. This phase is the responsibility of local Health Officers. In talking to several of them, it appears that one difficulty lies in the decision as to what should be done first. An organization capable of treating tens of thousands of casualties which have been produced in an instant, must include large numbers of trained individuals who have been organized into units, furnished with necessary equipment and supplies, and they also must have suitable places in which to work. This is a vast undertaking, including innumerable details, responsibilities and decisions. A start must be made somewhere. This is the time to decide where.

The number of casualties, considered in relation to the small number of professional people available, indicates that the bulk of the work will fall upon a large number of non-professional volunteers. Now is the time to train the volunteers and assign them to organizations.

The casualty clearing station is the place to which all of the casualties will be brought and where they will first be given the professional care of doctors, nurses and pharmacists. Each of these stations is designed to treat 600 casualties in 24 hours. These factors indicate the extreme importance of the casualty clearing station in meeting a disaster. Properly trained and equipped casualty clearing stations will reduce the number of deaths by half. Without properly functioning stations of this nature, the hospitals will be overrun and their professional people

will be handicapped in their work. With all of this in view, it seems best to focus our attention now on the casualty clearing station.

It is not necessary for all of the individuals required by the table of organization to be present in order to organize a casualty clearing station. As soon as key personnel have been gathered the completion of organization and training can be turned over to them. It is suggested that the local Health Officer select a leader who is interested in Civil Defense and ask that individual to start gathering the staff. This leader should be picked on the basis of enthusiasm and ability. He or she need not necessarily be a doctor or a nurse. In many instances a preacher, teacher, member of the P.T.A., or a pharmacist, may best serve. Then, as the organization progresses, the professional people can be added. The recruiting of volunteer first aid workers and nurses' aides should be started early, as many of these people will need training for their duties. The Red Cross has offered to train them.

Each casualty clearing station will need from five to ten first aid stations to gather casualties, give first aid, and transport them to the casualty clearing station. Each of these first aid stations will consist of three first aid teams. Each team comprises one leader and eight litter bearers, all trained in first aid.

Equipment and supplies for 150 casualty clearing stations and their satellite first aid stations is now being purchased from both Federal and State funds. The first of this equipment will be ready for issue in several weeks. The casualty clearing stations should be well organized in order to receive this equipment.

During the week 7 to 12 January, 1952, I will be attending the Federal Civil Defense Staff College at Olney. Upon completion of this course, I propose to visit all of the local Health Officers as rapidly as I can, in order to make myself available to them, and to assist in this work. Meanwhile, I hope that the first steps in organization will have been taken before my visit.

In first focusing attention upon casualty clearing stations, there is no intent to detract from the importance of all of the other Civil Defense activities.

¹ Chief, Medical Services, Civil Defense, Maryland State Department of Health.

It is believed that this is where we should begin and as soon as the organization of these forward stations is well developed, we will turn our attention to other echelons.

ALLEGANY-GARRET COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.,
Journal Representative

Dr. Leslie E. Daugherty, Medical Director for Civil Defense in Allegany County, announces the following appointees to the Steering Committee: Drs. William F. Williams, W. Alfred Van Ormer, Benedict Skitarelic, John K. Rozum, W. Oliver McLane, Jr., and J. Norman Reeves.

THE MEDICAL PROFESSION AND CIVIL DEFENSE

J. WILFRID DAVIS, M.D.¹

The first of the year 1952 is accompanied by an unwelcome carry-over from the year previous, the threat of enemy action in our own country. Particularly, the shadow of the atomic bomb darkens the

¹ Deputy Director, Baltimore City Civil Defense Health Service.

brightness and high hope which the beginning of a new year brings to most human beings.

Enemy attack in almost any form will entail casualties possibly numbered in scores of thousands. Physicians will be in most urgent demand. They will stand in the forefront of the battle. However, they will be appallingly ineffective unless they are well organized and properly directed. The medical section of our Civil Defense Organization is designed to provide necessary plans and leadership. This Organization requires and deserves the eager cooperation of every physician who can serve in Civil Defense.

When confronted with dangers of other kinds, physicians of Maryland have marched forward shoulder to shoulder to meet and overcome the threat that faced them. In the same spirit they will do their part in Civil Defense.

Let us hope that Maryland will never experience an enemy attack. Another atomic bomb may never fall. But a man insures his house even though he expects that fire may never destroy it. We should hope for the best but prepare for the worst. Looking for a ray of light in the shadow, let us not fail to note that even the threat of such dire things as atomic, biologic and chemical warfare in our country carries with it some solace—the satisfaction felt by physicians planning and working together in a great and worthy cause.

INSURANCE ECONOMICS SOCIETY OF AMERICA

Urges Shift In Old Age Assistance Planning

The general budget would be relieved of an annual burden of \$800 to \$900 million if the Federal government's share of current Old Age Assistance was placed under the Old Age and Survivor's Insurance Program, according to H. Albert Linton, president of the Provident Mutual Life Insurance Co. and president of the Life Insurance Association of America.

Mr. Linton told the closing session of the association's 45th annual meeting that "such a move would probably reduce political pressures. We of this generation would understand more fully the true costs of pensions. If benefit levels were to be raised for those currently on the rolls, money would have to be found immediately to pay the increased costs. We would, therefore, be less likely to promise unduly high benefits for others to pay in the future. There would be no temporary excess of income over outgo in the O.A.S.I. system as at present to make it appear feasible to set benefits at unsound levels which could impose a future dangerous burden upon the economy of the country."

Health Departments

BALTIMORE CITY HEALTH DEPARTMENT

The New Communicable Disease Chart

In 1934 and again in 1940 and 1946, the Baltimore City Health Department has issued a chart designed to show the isolation requirements and additional clinical and epidemiological information for some of the more important communicable diseases, particularly those that affect children.

Charts of like nature have been used in some of the counties of Maryland and in other States, and they have been useful both to the members of the medical profession, and also to Health Department physicians and public health nurses, and school teachers.

On April 20, 1951, the Baltimore City Health Department adopted its latest revised Communicable Disease Chart as Regulation 2 pursuant to the authority of City Ordinance No. 217, Approved June 20, 1945.

The revised edition, based on up-to-date nationally recognized sources, was prepared in close collaboration with the health officers of Baltimore County and Anne Arundel County and the Maryland State Department of Health. The Commissioner of Health of Baltimore City welcomes this opportunity of presenting the newly revised chart to the readers of the *Maryland State Medical Journal*.

Huntington Williams, M.D.

BALTIMORE CITY HEALTH DEPARTMENT REQUIREMENTS FOR COMMUNICABLE DISEASES

Pursuant to Ordinance No. 217, Approved June 20, 1945, and Ordinance No. 693, Approved December 2, 1946, the following regulation for the control of communicable diseases has been adopted, effective April 20, 1951.
This Regulation, Regulation 2—Control of communicable disease, has been prepared in chart form for the use of health officers, physicians, school authorities, public health nurses and others, to serve as a ready reference to facts regarding several of the more important communicable diseases and the requirements of the Baltimore City Health Department concerning them.

1 DISEASE AND INCUBATION PERIOD	2 COMMON EARLY SIGNS AND SYMPTOMS	3 METHOD OF INFECTION	ISOLATION REQUIREMENTS				8 ISOLATION OF INCIDENTAL CONTACTS	9 REMARKS
			4 ISOLATION OF PATIENT	IF PATIENT AND CONTACTS REMAIN AT HOME		7 ISOLATION OF HOUSEHOLD CONTACTS IF PATIENT GOES TO HOSPITAL OR CONTACTS LEAVE HOME		
				5 ISOLATION OF CONTACTS UNDER 16	6 ISOLATION OF ADULT CONTACTS			
CHICKENPOX Incubation Period: 11-24 days. Usually 13-16 days.	In children the first symptom noticed is usually the rash which when first seen consists of small blisters that have developed from small pimples. In a day or two crusts form which fall off in about 14 days. The eruption comes out in crops so that there may be pimples, blisters and scabs all within a small area of the skin.	Contact with a previous case. Infection believed to be contained in discharges from throat and nose and in the skin lesions.	Until recovery. Usually not over 7 days after first appearance of rash.	No.	No.	No.	No.	Very communicable. A mild disease and seldom any after-effects. Important because of possible confusion with smallpox. The long and variable period of the incubation and the mildness of the disease do not warrant the isolation even of susceptible contacts.
DIPHTHERIA Incubation Period: Minimum less than 1 day; maximum, indefinite. Usually 2-5 days.	Sore throat is usually the first symptom in patients over a year old. In very young children it is apt to be croup. In the latter there may be no patches showing, but in the former they can always be found in "typical" cases either on the throat itself, tonsils or palate, sometimes on all of them. Some cases look like simple tonsillitis. In nasal cases discharge from nose occurs which usually excoriates the upper lip and may be bloody. Diphtheritic croup means diphtheria of the larynx. It is an exceedingly dangerous form of the disease.	Contact with a previous case. Discharges from throat and nose convey infection. Unpasteurized milk may convey infection. Often spread through mild, unrecognized cases, or by persons harboring the germs of the disease, though giving no evidence of having had an attack of diphtheria (carriers).	Until 2 successive cultures each from throat and nose taken at least 24 hours apart contain no virulent and no virulent diphtheria bacilli.	Yes. Until patient is released from isolation and cultures from both throat and nose show no virulent and no virulent diphtheria bacilli.	No. Provided (a) patient is properly isolated, and both throat and nose show no virulent diphtheria bacilli; and (b) occupation of contact does not involve the handling of food or bring the contact into close association with children.	No. Provided cultures from both throat and nose show no virulent diphtheria bacilli.	No.	Very dangerous, both during attack and from after-effects. The younger the child the greater the danger from diphtheria. There is a great variation of type, and mild cases are often not recognized until a culture is taken or subsequent paralysis develops. CHILDREN MAY BE PROTECTED AGAINST DIPHTHERIA BY TOXOID INOCULATION. EVERY CHILD SHOULD RECEIVE A SERIES OF PROTECTIVE INOCULATIONS OF DIPHTHERIA-PERTUSSIS-TETANUS TOXOID BEGINNING EARLY IN THE FIRST YEAR OF LIFE, AND LATER, BOOSTER DOSES OF THIS MATERIAL.
GERMAN MEASLES Incubation Period: 12-21 days from exposure to initial symptom, usually 14-16 days. Usually 18 days from exposure to appearance of rash.	Illness usually slight. Onset sudden. Lymph nodes in back of neck usually enlarged. Rash often first thing noticed. Cold in head not a prominent symptom. May have fever, sore throat, and eyes may be inflamed. Rash variable; may resemble measles or scarlet fever, or both.	Contact with a previous case. Discharges from throat and nose of a patient convey infection.	Until recovery.	No.	No.	No.	No.	A mild disease, occasionally confused with measles or scarlet fever.
MEASLES Incubation Period: 8-12 days from exposure to initial symptom, usually 9 or 10 days; 11-15 days from exposure to appearance of rash.	Begins with fever followed by symptoms like cold in the head, with running nose, sneezing, inflamed and watery eyes. The rash is usually first seen behind the ears, on forehead and face; it is blotchy and usually dusky red in color.	Contact with a previous case. Discharges from throat and nose of a patient, especially in the early days of the disease before the rash appears, convey infection.	Until recovery.	No.	No.	No.	No.	Very communicable, especially during the first few days before the rash appears. Practically everyone who has not had the disease is susceptible. Because of the facts measles occurs characteristically in epidemics. <i>Efforts to cut their epidemics short through the isolation of contacts are seldom successful and cause much inconvenience and loss of school time.</i> The primary object should be the prevention of deaths through adequate medical and nursing care. Parents should be instructed in early symptoms and told to keep the child home if these develop. If found in school, the child should be sent home and the Health Department notified of name and address. Measles is very dangerous to children under 3 years of age. School children nearly always recover unless they are in poor physical condition and are not properly cared for during illness.
MENINGOCOCCUS MENINGITIS Incubation Period: 2-10 days	Onset usually sudden, with vomiting, fever, headache and stiffness of neck.	Contact with a previous case or carrier.	Until end of the febrile stage	No.	No.	No.	No.	Infection apparently conveyed chiefly by carriers.

Incubation Period: 12-26 days. Usually 17-21 days.	Onset of disease usually with fever, dull pain on bending neck forward, pain on being handled, headache and vomiting. Sometimes sudden development of weakness of one or more muscle groups.	Contact with a previous case. Discharges from throat and nose of a patient convey infection.	Until end of the febrile stage.	No.	No.	No.	No.	Very communicable. Intimacy or contact may occur after the age of puberty. Otherwise not a serious disease.
POLIOMYELITIS Incubation Period: Usually 7-14 days.	Onset sudden, with fever, dull pain on bending neck forward, pain on being handled, headache and vomiting. Sometimes sudden development of weakness of one or more muscle groups.	Apparently contact with a healthy carrier of the virus or with a recognized or unrecognized case. Discharges from the throat and nose of a carrier or a patient apparently convey infection.	Until end of the febrile stage.	No.	No.	No.	No.	Infection apparently conveyed chiefly by throat and nose discharges of carriers. Virus has been found in bowel discharges of infected persons. After-effects often paralysis of certain muscle groups, transitory or permanent. Death is usually due to paralysis of respiratory muscles.
SCARLET FEVER Incubation Period: 1-7 days. Usually 2-3 days.	Onset usually sudden, with headache, fever, sore throat, and often vomiting. Glands (lymph nodes) of neck usually enlarged. Usually within 24 hours the rash appears as fine, evenly diffused bright red dots. The rash is first on the neck and upper part of the chest and lasts 2-3 hours to 10 days, when it fades and the skin peels in scales, flakes or even large pieces.	Contact with a previous case or carrier. Discharges from throat and nose, spreading from glands or ears of a patient. Unpasteurized milk may convey infection. Often spread by mild, unrecognized cases.	Until the mucous membranes of the throat and nose appear normal. Discharges from throat and nose cease; abnormal discharges from the throat, nose, ears and suppurating glands have ceased; provided that such isolation shall continue for not less than 7 days and not more than 90 days from onset.	No.	No.	No.	No.	Running ears, discharging noses or suppurating glands may greatly prolong the infectious period. Mild unrecognized cases, or carriers are important in spread. Very mild cases may show little rash, and the peeling may not be noticeable.
STREPTOCOCCAL SORE THROAT (SEPTIC SORE THROAT) Incubation Period: Same as scarlet fever.	Same as scarlet fever but without the rash.	Same as scarlet fever.	Same as scarlet fever.	No.	No.	No.	No.	Same as for scarlet fever, but omitting references to rash and peeling.
SMALLPOX Incubation Period: 7-21 days. Usually 12 days from exposure to initial fever and 15 days from exposure to appearance of rash.	Onset sudden, usually with fever, headache and severe backache. About third day usually upon subsidence of constitutional symptoms there develop red pimples felt below the skin and seen first about the face and wrists and mostly on exposed surfaces. They form small blisters and 2 days later become filled with yellowish matter. Scabs form which begin to fall off about the fourteenth day. In mild cases the pimples and blisters may closely resemble those found in chickenpox.	Contact with a previous case. Discharges from throat and nose convey infection. Contents of pustules are also believed to convey infection.	Until 14 days after onset and until skin has healed. Patient usually required to accept hospitalization in the Sydenham Service at Baltimore City Hospital.	Yes. Until 21 days after isolation of patient has been terminated. Vaccination required.	Yes. Until 21 days after first exposure may be released from isolation as soon as Health Department determines vaccination has been successful.	Yes. Until 21 days after last exposure. Vaccination required. May be released from isolation as soon as Health Department determines vaccination has been successful.	Yes. Until 21 days after last exposure. Vaccination required. May be released from isolation as soon as Health Department determines vaccination has been successful.	Very communicable. Cases of modified smallpox may be detected often as slight rash, but may be concealed. A severe type of infection may result from exposure to a mild case. Every child should be vaccinated before the age of one year.
WHOOPING COUGH Incubation Period: 2-14 days. Usually 5-8 days.	Begins with cough which is worse at night. Symptoms may at first be very mild. Characteristic "whooping" develops in about 2 weeks, and the spasm of coughing sometimes ends with vomiting. If a child vomits after a hard spell of coughing, he probably has whooping cough. Some children with mild whooping cough never "whoop" or vomit.	Contact with a previous case. Discharges from throat and nose, especially in the early stages before the "whoop" begins.	Patient restricted from associating with children or attending public assemblies until 28 days after onset and until recovery, but not more than 8 weeks.	No.	No.	No.	No.	After-effects often very severe and disease causes great debility. Relapses are apt to occur. Second attack rare. Especially communicable for first week or two before the "whoop" occurs. Great variation in severity of cases. Often fatal in young children and the weak and aged. Over half the deaths are in children less than a year old and over 95 per cent are in children under 5 years of age. CHILDREN MAY BE PROTECTED AGAINST WHOOPING COUGH BY PREVENTIVE INOCULATION. EVERY CHILD SHOULD RECEIVE A SERIES OF PROTECTIVE INOCULATIONS OF DIPHTHERIA-PERTUSSIS-TETANUS TOXOID BEGINNING EARLY IN THE FIRST YEAR OF LIFE, AND LATER, BOOSTER DOSES OF THIS MATERIAL.

Issued by Bureau of Communicable Diseases
MYRON G. TULL, M.D., Director
HUNTINGTON WILLIAMS, M.D., Commissioner of Health

Insurance

BLUE CROSS

The year 1951 was one of great activity and important change for Blue Cross. It had hardly begun when Director J. Douglas Coleman announced that he was leaving to accept a position as Vice-President of both The Johns Hopkins University and The Johns Hopkins Hospital. He has assumed the responsibilities of managing the fund raising program of these two institutions. Mr. Coleman was the original Director of Maryland's Blue Cross and had steered its course from its infancy to an enrollment of 800,000. It was fortunate indeed that Mr. R. H. Dabney, his assistant for four years, was available as Mr. Coleman's successor.

The next major change was the move in May to 200 West Baltimore Street. The offices on Baltimore Street and Fayette Street were consolidated on the first two floors and mezzanine of the Butler Building. Everybody is now settled and all is running very smoothly. Visitors are welcome at any time to inspect the new headquarters.

Before and during these changes, it was becoming

more and more evident that certain alterations had to be made in the Blue Cross benefits and rates. The fact that hospital costs (and consequently Blue Cross') had increased, made the rate change inevitable. Therefore, on December first new rates and improved benefits were put into effect. Included in the latter, are maternity benefits—up to \$75.00 credit for any one pregnancy—and also 21 days of hospital care for each hospital case, provided stays are separated by at least 90 days.

With the above changes Blue Cross has continued to grow. In the past year over 40,000 new members have joined making a total (as of December 1st) of 840,512.

This information was presented at the annual Blue Cross Corporation dinner held Wednesday, January 30, at the Sheraton Belvedere Hotel. Among those who attended were, the member hospital administrators, the Board of Directors of Maryland Hospital Service, Incorporated and various administrative personnel of Blue Cross.

DEFENSE DEPARTMENT, UMT COMMISSION SUPPORT AMA ON MEDICAL STUDENT DEFERMENT. CAPITOL CLINIC VOL. #3, NO. 3

Defense Department and National Security Training Commission are in agreement with the American Medical Association that pre-medical and medical students, after six months of Universal Military Training, should be deferred from service in the reserves until completion of their schooling and internships. The two agencies presented their views before the House Armed Services Committee, which is holding hearings on bills to implement UMT. If Congress puts UMT into effect, it will be run by Defense Department but supervised by the Civilian Commission.

For the first year at least, deferment would not be an important factor, as Defense Department contemplates starting out with only 60,000 eighteen year old volunteers. Eventually as many as 800,000 inductees could be trained annually.

Hospital News

LICENSING OF HOSPITALS

H. G. FRITZ¹

Maryland has had a hospital licensing program since 1945. The Law² enacted that year by the Legislature provided for the licensing of hospitals and authorized the State Board of Health to promulgate rules and regulations prescribing certain minimum standards for hospitals.

Currently 221 institutions, with 24,116 beds fall within the purview of the program. The Law defines a hospital as "any institution which maintains and operates facilities for the care and/or treatment of two (2) or more non-related persons as patients suffering mental or physical ailments."

ADVISORY BOARD

The Law specifically places responsibility upon the State Board of Health for the administration of the program. It also establishes an Advisory Board which "makes recommendations to the State Board of Health" and assists "in the establishment of minimum standards." This Board³ is composed of three members nominated by the Medical and Chirurgical Faculty and four members nominated by the Maryland-District of Columbia Hospital Association. Of the Hospital Association nominees, two are required to be hospital administrators, one a hospital trustee, and at least one must be a member of the Medical and Chirurgical Faculty. Dr. Winford H. Smith is currently Chairman of this Board.

This Board collaborated with the personnel of the Department of Health in preparing the original rules and regulations and has reviewed and recommended to the State Board of Health all later modifi-

cations. It meets, on call, to consider problems as they arise. Problems stem largely from nursing homes which have failed to comply with regulations. Decisions must be made as to what will be accepted as compliance, as well as an acceptable schedule of progress toward comppliance, or recommendation of closure to the State Board of Health.

SCOPE

Institutions covered by the program range from nursing homes with two or three beds to large ones having as many as 100 beds, and hospitals in all categories and sizes.

Institutions now listed are grouped as follows:

Category	Number of Institutions	Number of Beds
General Hospitals	42	8,221
Special Hospitals		
Mental	17	10,113
Tuberculosis	6	1,252
Chronic Disease	4	561
Others	11	393
Nursing homes	141	3,576
	221	24,116

The number of institutions licensed has not been subject to much fluctuation. Few new hospitals have been built, most construction in recent years being in the form of additions to existing institutions. The number of new nursing homes established has balanced with the number closing.

REGULATIONS

Because of the diversity of facilities needed in the various classes of institutions, two sets of regulations are in use. One set covers acute general and special hospitals. Nursing and convalescent homes are covered by the second set.

The Regulations deal with interpretations of the law for the purpose of defining the institutions re-

¹ Chief, Division of Hospital Services, State Department of Health.

² Chapter 210, Laws of Maryland 1945.

³ Winford H. Smith, M.D. (6-1-53); Mr. William L. Galvin (6-1-54); William D. Noble, M.D. (6-1-56); Mr. P. J. McMillin (6-1-52); Mr. J. Douglas Colman (6-1-55); J. Oliver Purvis, M.D. (6-1-54); and I. Ridgeway Trimble, M.D. (6-1-52).

quired to obtain a license, but largely with hospital services and facilities required to be maintained. In areas where other agencies carry responsibilities and have established regulations or codes, the regulations for this program are not spelled out in detail. For instance, in the case of fire safety, the State or local fire authorities are called upon to make inspections and submit recommendations in line with the regulations under which they function. Institutions must comply with these recommendations to qualify for a license. The same procedure is used in the field of Sanitary Engineering covering water supply, sewage disposal, sanitary inspections and building codes.

Functioning in this manner the State Department of Health coordinates the inspections of other agencies adding only those areas not previously covered such as space standards for beds, facilities, and other hospitals aspects.

PERSONNEL

The use being made of other inspecting agencies and bureaus and divisions within the Department leave only the specific hospital elements of an institution to be covered. The field work, that is interviews with persons wishing to establish a new institution, routine inspections and follow up on recommendations, is done by three Hospital Advisors. Hospital Advisors are nurses with college degrees, supplemented by experience in public health or hospital administration.

Shortly after the Division of Hospital Services was established to administer the hospital construction program under the Federal Hospital Survey and Construction Act (Hill Burton Bill), the licensing program was transferred to this Division. This brought into direct relationship with the hospital licensing program the services of a hospital administrator who functions as Chief of the Division, an architectural engineer, an architect, and the part time services of a consultant dietitian. In cooperation with the Hospital Advisor, the services of these specialists are used as the need arises.

PROGRESS

Results of the program at the end of five years cannot be tabulated in the form of a profit and loss statement. However, there is tangible evidence that it has effected an improvement of hospital facilities, services and safety throughout the State.

Early reports from fire authorities were voluminous because of numerous hazards and deficiencies found. Recent reports in most instances are certifications to the effect that there are no current violations. The violations consisted of such conditions as non-functioning fire exit doors. In others, exits were blocked by equipment. In some cases fire exit lights were not lighted. Fire extinguishers were found empty or outdated. Inflammable material such as paint and oil mops, were improperly stored. In some cases additional fire exits and fire escapes were required. Where defective wiring was found it was ordered replaced. The number of extension cords plugged into one outlet was found to be excessive and ordered reduced in number. Fire alarm systems were ordered installed. These and many other hazards which previously had been neglected or overlooked have been corrected. Inspections at regular intervals insure against another accumulation of these and similar hazards.

The Department has added the requirement that instructions for procedure in case of fire be written and posted throughout the institution.

From the point of view of hospital services, the improvement in nursing homes has been more dramatic than in general and special hospitals. At the beginning of the program nursing homes were categorized in three groups. The first group consisted of those homes which essentially met the regulations. The second group was made up of homes which could be brought into compliance with certain changes or improvements. The third group was made up of homes which showed no possibility of being brought into compliance.

The closure of the third group has been slow because of the dearth of nursing homes and chronic disease hospital beds. It can be reported that with only two exceptions none of this group is in operation today. The two remaining of this group have made considerable progress toward compliance, having met fire and safety requirements.

New nursing homes are inspected and required to comply before opening. The new ones, having been approximately equal to the number closing have therefore raised the general average for all nursing homes.

In addition to improvement in the physical plants very important progress has been effected in the functioning of nursing homes. Every nursing home

now has in attendance a "principal physician." His affiliation with the institution is a matter of record with the State Department of Health. His commitment includes emergency calls and responsibility for the medical policies of the institution. The medical profession's increasing interest in geriatrics is assumed to be a contributory factor to the physician's willingness to establish this type of relationship with nursing homes. The influence of the principal physician, coupled with the insistence of the Health Department is effecting the establishment of improved medical records and better standards of care.

Patients are no longer placed in beds in overcrowded rooms. Standards of floor and window areas are enforced, thus insuring adequate space, light and ventilation.

In the area of hospitals there has also been considerable progress. One new hospital is under construction and will replace an old one which was considered too hazardous to warrant remodeling. Another hospital has under construction an addition which will provide a satisfactory solution to several conditions which were in violation of regulations for licensing.

NEW CONSTRUCTION

The progress commented upon has in many cases been difficult to accomplish. There is still much to be attained before it can be reported that all hospitals and nursing homes are in full compliance. Some problems will not be overcome until hospitals find sufficient money to construct additions or new buildings of sufficient capacity to accommodate their present overload, the unmet need for hospital beds, viz: the waiting lists and the patients now housed in facilities which cannot economically be made to meet modern standards.

FISCAL ASPECTS

Cost of construction and equipment has reached such a high point that institutions are finding it difficult to obtain funds in sufficient amounts to proceed with construction programs. The Hill Burton Bill was intended to reduce the local cost through Federal Grants. Since 1946 when the Hill Burton Bill became law, costs have increased beyond the amount of Federal assistance. Hospitals are therefore utilizing buildings and equipment which they

would prefer to replace but find it impossible to do so. In the interim, the licensing program is being directed toward making these structures safe by providing fire fighting and prevention facilities, fire exits, and keeping them free of hazards.

The nursing home situation is comparable. High construction costs and limited ability of patients or their relatives to pay high rates over an extended period make it impossible and impracticable for operators to erect new buildings. Nursing homes are therefore established in converted dwellings. Under the licensing program these buildings are maintained at safe standards.

Patients needing nursing home care frequently are dependent upon limited personal resources, support from relatives or welfare grants. Insistence upon installation of expensive equipment and remodeling, except in safety measures, is scheduled at a rate consistent with income. After safety, adequate food and bedside care is preferred to capital improvement. During periods when progressive improvement is being accomplished and adequate food and service are maintained, "provisional licenses" are issued.

EDUCATIONAL ASPECTS

The services of all personnel of the Department are freely called upon for consultations in their respective field. On occasion calls have been made upon the services of individuals not in State employment, for advice or consultation with personnel of institutions having special problems.

Plans are being developed for short courses of instruction for nursing home operators on subjects such as housekeeping, medical records, dietary, and other nursing home services.

SUMMARY

The hospital licensing program is a continuous effort to upgrade institutions falling within the purview of the law establishing the program. Conditions as they existed when the program was initiated compared with those prevailing currently reveals that considerable progress has been made, especially in nursing homes.

High cost of construction, service and supplies, and limited personal resources and grants from public funds retard the rate at which complete compliance with regulations can be accomplished.

Woman's Auxiliary to the Medical and Chirurgical Faculty

NEWS OF COMPONENT AUXILIARIES

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

The Woman's Auxiliary to the BALTIMORE CITY MEDICAL SOCIETY, at the February 6, 1952 meeting heard Mr. John W. Payne, Executive Director of the Good Will Industries, explain how the Good Will Industries manage to assist the handicapped without Federal Aid.

BALTIMORE COUNTY AUXILIARY held its annual election of officers at the home of the President, Mrs. George E. Urban, on December 14th. Their new officers are as follows: Mrs. Martin E. Strobel, President; Mrs. Howard W. Frederickson, Vice-President; Mrs. Charles W. Kerr, Recording Secretary; Mrs. James E. Peterman, Corresponding Secretary; Mrs. Elliott E. Flick, Treasurer.

Members of the Auxiliary to the PRINCE GEORGE'S COUNTY MEDICAL SOCIETY report that their fashion show and luncheon to raise funds for a Nurse's Scholarship was a great success. Because of their generosity in contributing to various health drives throughout the year and in giving such a substantial donation to their Doctors' Library, the Auxiliary will require additional funds before this scholarship can be established.

Rumor has it that the WASHINGTON COUNTY AUXILIARY is considering the idea of holding a Charity Ball. If they do, we hope that its success will make it a yearly event of importance in Hagerstown.

We have no report from DORCHESTER, MONTGOMERY, CECIL OR FREDERICK COUNTY AUXILIARIES.

THE AUXILIARY CIVIL DEFENSE PROGRAM

MRS. E. IRVING BAUMGARTNER

As members will recall, The Woman's Auxiliary to the Medical and Chirurgical Faculty pioneered in requesting all women's organizations and clubs to hold Civil Defense meetings, to show Civil Defense

movies, and to distribute a pamphlet called "Survival Under Atomic Attack." Several prominent National and state-wide women's groups as well as a great many independent local associations adopted our suggestions.

As a result, Civil authorities were flooded with requests for speakers and for the two Civil Defense movies then available. Our State Auxiliary initiated this program of Civil Defense due to suggestions made at the Chicago Conference of the Woman's Auxiliary to the American Medical Association, of which we are a part, and which was attended by our President and President-Elect.

This year Mrs. Yeager and Mrs. Williams have returned from the Chicago Conference with additional suggestions from our National body for work in Civil Defense. We should encourage our own members and those of other Civic Organizations, and all individuals in our Communities, to have their blood typed as soon as possible, and to obtain identification tags stamped with their blood type, name, and address.

Every one making the effort to take a First Aid course or to contribute blood to the blood bank, acts not only for the public safety but in self defense in case of disaster. For my own part, as your Auxiliary Chairman of Civil Defense, I have taken the orientation course conducted by the Federal and State Civilian Defense officers, to better qualify myself for the responsibility of informing the Auxiliary and the public about Civil Defense needs.

Auxiliary members and members of other interested groups, can render public service to their communities by making a door-to-door survey of the houses in their immediate neighborhood to learn whether the householders have prepared a First Aid kit, a shelter and food supplies in case of emergency. They should be asked whether they have taken necessary fire precautions; a First Aid course; given blood; had their blood typed, acquired identification

tags; and have read the following pamphlets, "Survival Under Atomic Attack," published last year and the newer ones "Fire Fighting for Householders," "Civil Defense Household First Aid Kit" (to be kept with the kit), and "Emergency Action to Save Lives." The latter pamphlet explains what rescuers should not attempt if they have not studied First Aid. In rural areas, where animals and crops must be protected from destruction and contamination, people should be asked to read "What You Should Know About Biological Warfare." All these pamphlets are procurable from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for the sum of five or ten cents per copy. If component Auxiliaries, and other organizations, do not choose to buy and distribute these pamphlets, individual members might purchase a few to distribute during their neighborhood door-to-door survey. At least, neighbors should be given the source from which they may be obtained and informed of the necessity of reading them.

This will emphasize further the most important aspect of Civil Defense,—the self-dependence of each citizen and family. It is a fact that preparations made by the individual ahead of time, will be his only protection. All public assistance will be needed elsewhere. Survival will be dependent upon individual effort.

The Maryland State Auxiliary has informed its Component Auxiliaries of the location of Area Civil Defense Directors. Reliable information indicates that Doctors' wives can serve best by working, under the Doctors, in their local Casualty Clearing Stations. A great many wives of Physicians are trained nurses, dietitians, or have done some type of hospital work. For this reason Civil Defense authorities feel that we may be most useful by helping in both the City and Counties in the organization of medical supplies and other work attendant upon the establishment of Casualty Clearing Stations. Members of non-medical women's organizations should be urged to become Civil Defense Officers, as they would make excellent Air Raid Wardens, Auxiliary Police, etc.

Preferably, we should sign up for service in the nearest Casualty Clearing Station, which would be composed largely of medical personnel.

In rural areas, particularly, the doctor and his wife are Civil Defense! The doctors have helped plan the Civil Defense program and some of them have taken the special orientation course in order to better protect their communities. For rural or city Auxiliaries desiring Civil Defense program material, there is a speaker's kit available on "Biological Warfare" from Thomas Meecham, Director of Public Liaison Division, Public Affairs Office, Federal Civil Defense Administration, Washington 25, D. C. A doctor or one of your own members could give a talk on this timely subject.

Finally, there are three excellent Civil Defense movies, which were not available last year and which Auxiliaries and other organizations can obtain from their local Area Civil Defense Directors or Coordinators. These films are "Tale of Two Cities," 12 minutes, "Survival Under Atomic Attack," 9 minutes, and "Fire Fighting For Householders," 9 minutes. These are 16 m.m. sound track films and, in the City, come spliced together. In Baltimore City, Civil Defense authorities will provide a projector and operator to show these pictures. In the Counties the authorities will make the best possible facilities available. For instance, in some Counties a speaker will be provided who will also operate the movie projector.

We must continue our program of urging not only our Auxiliaries but all other Civic groups as well, to devote one meeting a year to Civil Defense. This is especially important in Maryland which is one of the critical target areas of the United States. Maryland is always mentioned as a known target for enemy bombers. Furthermore the Department of Defense tells us enemy bombers could successfully complete their mission. We shall have helped to meet this grim challenge by making the individual citizen aware that Civil Defense is essentially self defense, and that everyone must personally take the initiative to protect himself, his own family, home, and community.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Administrator*

Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations

STUDENT NURSE RECRUITMENT

MARGARET COURTNEY, R.N.

To help meet the continuing demand for nurses a Joint Committee on Careers in Nursing has been appointed by the Joint Board of Directors of the Three Maryland State Nursing Organizations—Maryland State Nurses Association, Maryland State League of Nursing Education, and the Maryland State Organization for Public Health Nursing. This committee will work in cooperation with members of allied professions and other groups in the interest of securing well-qualified students for schools of nursing. It will endeavor to keep before the public the opportunities and satisfactions of a career in nursing. It will provide prospective students with information regarding approved schools of nursing. The committee will recruit not for individual schools, but for the nursing profession.

Recognizing that physicians are in strategic positions to interest and guide young women in their choice of a career, this committee urges that each physician participate in this effort to meet present and future nursing needs. Individual guidance such as this will be of inestimable value in securing more students for our schools of nursing.

Current and detailed information regarding entrance requirements, programs of study, etc., is essential for guidance. Such information can be secured from individual schools of nursing or from the Joint Committee on Careers in Nursing, 1217 Cathedral Street, Baltimore 1, Maryland. The committee would welcome inquiries from physicians or from prospective students in nursing. Arrangements for personal interviews can be made by writing to the Committee or by calling Vernon 7567.

THE JOHNS HOPKINS HOSPITAL SCHOOL OF NURSING

Refresher Program

The Johns Hopkins Hospital School of Nursing offers a four weeks refresher program to graduate nurses. April 15–May 12, 1952.

The program will include a minimum of thirty hours of conferences and classes, with nursing practice providing a weekly schedule of forty hours. Topics to be discussed will be as follows:

Present Concepts of Patient Care

Review of Systems of Measurement, Problems in Dosage and Solutions, and Administration of Drugs

Basic Nursing Care Including Review of Medical and Surgical Asepsis Nursing Care of Patients with Medical and Surgical Conditions—Medical and Psychological Therapy, Pre and Post Operative Care, Early Ambulation—Use of New Drugs and Antibiotics—Diet Therapy—Oxygen Therapy—Radium Therapy—Use of Respirators—Traction—etc.

Graduate nurses interested in this program should apply not later than April 1st, 1952 to The Director of the Nursing School and Nursing Service, The Johns Hopkins Hospital, Baltimore 5, Maryland.

MARYLAND STATE NURSES ASSOCIATION

M. RUTH MOUBRAY, *Executive Secretary*

At the annual convention of the Maryland State Nurses Association held in November 1951 the terms of some of the officers terminated and new officers were elected. For your information we are listing below the present officers of the Maryland State

Nurses Association. All of them may be addressed at the headquarters office of the Maryland State Nurses Association, 1217 Cathedral Street, Baltimore 1, Maryland. *President*, Miss Martha Johnson; *Second Vice-President*, Sister M. Florence; *Secretary*, Miss

Irene J. Coleman; *Treasurer*, Miss Donnie M. Bay; *Directors*, Miss Elizabeth W. Sherwood; Miss Eleanor M. Harris; Miss Winnie A. Coxe; Miss Anna E. Holmes; Mrs. Lois W. DeBrule, and Miss Ethel Turner.

PHARMACY SECTION

L. M. KANTNER, Phar.D.

QUACKERY VS. SCIENTIFIC MEDICINE

Quackery still stalks in this enlightened age. Statements, which are unquestionably true such as "the American people receive the best medical treatment in the world" give members of the healing arts professions cause for pride. The American hospital is truly a wonderful institution. The facilities for the diagnosis of disease—and the wide array of medicinals that the physician has at his command to perform miraculous cures—give the public a deep sense of security so far as health protection is concerned. In spite of great scientific advances, attention is now and then focused upon the detection of unscrupulous operators who claim that their quack treatments produce definite cures.

Recently such an operator, who masqueraded under a self-conferred M.D. degree, was convicted in a western state for treating cancer, diabetes, arthritis or any other physical ailments of patients who applied. Federal and state food and drug officials are constantly on the lookout for such practitioners.

It is difficult to understand why people, regardless of their literacy, will gamble with their health, or even with their lives, and fail to recognize such charlatans. Unexcelled medical care is now available to people in all walks of life in this country.

Maryland is fortunate in that it does not have to

contend with operators who dispense or manufacture medicinals as treatments for illnesses that actually require high-grade medical care. Under the Maryland law no drugs or medicines can be manufactured without a permit issued by the Board of Pharmacy. The Board requires that every applicant for such a permit submit the formula for the preparation, together with all printed matter to accompany it, if, or when it is sold. This method effectively prohibits fraudulent medicines from being manufactured or distributed.

"Medicine shows" that were popular not so many years ago are prohibited here. Recently a widely advertised medical preparation was being advertised by means of "caravans" employing popular "motion picture stars" as performers. These exhibitions or entertainments were presented in stadiums and other large places of public assembly and the purchase of a carton of the medicine was the only requirement for admission to the show. The sponsoring organization was served notice that Maryland did not permit such exhibitions, with the result that it by-passed this state.

Note to Doctors: The State Board of Pharmacy believes that it would be a splendid idea to adopt a policy of including on your prescriptions (except narcotic prescriptions) instruction to refill—as Refill 1-2-3-4, not to refill—as N.R., or to refill P.R.N.

APPROPRIATION REQUESTS OF INTEREST TO MEDICAL PROFESSION

Capitol Clinic, Vol. #3, No. 3

(Budget requests shown below are subject to increase or decrease by committees or on floor of House and Senate. They will provide funds for the period of July 1952 through June 1953, identified as "fiscal 1953." Figures shown below are in millions.)

	<i>Provided by Congress For Fiscal 1952</i>	<i>President's Requests For Fiscal 1953</i>
Civil Defense, medical stockpiling*	\$ 50.0	\$193.0
National Science Foundation	5.0	15.0
Public Health Service	334.5	292.4
Hill-Burton Hospital Construction	82.5	75.0
National Institutes of Health	16.8	15.5
Cancer Institute	20.6	16.7
Heart Institute	13.0	9.7
Children's Bureau, grants	31.5	30.0

* Civil Defense appropriations carry no new money for state-matching grants for medical stockpiling. The 1952 grants, according to the budget, are sufficient to assist all critical target areas to provide first-aid supplies and equipment for the first four hours after an attack. The \$193 million listed above is for wholly federal procurement of medical supplies, based on CDA estimates that 2,700,000 casualties could be cared for with this amount of supplies.

No request was made at this time for funds for school and hospital construction in crowded defense areas, but \$15 million may be asked later. Enough money was asked for Veterans Administration hospital construction to pay for construction already approved by Congress. Military Departments' budgets are not complete; Congress will be asked to consider them in supplemental appropriations bills. Health, welfare and education requests from all departments and agencies for fiscal 1953 are placed at \$2,662 million, as against \$2,680 million actually appropriated for fiscal 1952.

RURAL HEALTH TO BE NATIONAL CONFERENCE TOPIC

News Release from The American Medical Association

The problems of medical care in small communities were discussed at the seventh annual National Conference on Rural Health, in the Shirley-Savoy Hotel, Denver, February 29 and March 1.

The gathering, the most important of the year from a rural health standpoint, was sponsored by the Council on Rural Health of the American Medical Association, with the cooperation of farm organizations. It brought together about 700 medical, farm, civic and agricultural education leaders from all over the country. The theme was "Help Yourself to Health."

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 1

March, 1952

NUMBER 3

ONE HUNDRED FIFTY-FOURTH ANNUAL MEETING

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

1211 Cathedral Street, Baltimore 1, Maryland

ANNUAL MEETING PROGRAM

Tuesday, April 29, 1952

8:00 a.m. to 12 noon. OPERATIONS POSTED

MEMBERS WELCOME

The Johns Hopkins Hospital, Schedule Posted—Halsted Lobby
The University Hospital, Schedule Posted—8th Floor Rotunda

Morning Session

9:00 a.m. Visit the Exhibits—Tent, Supper Room, and Basement Corridor.
Entrance on Maryland Avenue.

OSLER HALL

(Entrance and Exit—Maryland Avenue)

9:00 a.m. Motion Pictures.

1. Respiratory Exercises in Emphysema. (10 minutes.) Discussed by **Warde B. Allan, M.D.**

Produced in The Johns Hopkins Hospital and The School of Medicine of The Johns Hopkins University.

2. The Surgical Treatment of Involuntary Movements. (30 minutes.) Discussed by **A. Earl Walker, M.D.**

Produced in part in The Johns Hopkins Hospital and The School of Medicine of The Johns Hopkins University.

(Continued on page 123)

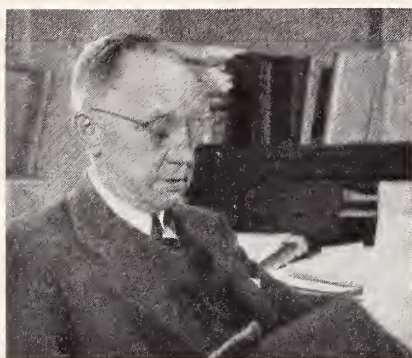
SEE THE CREATIVE ARTS SHOW

Second Floor, Frick Reading Room

Visit the A.M.A. Exhibits—Main Floor Corridor

ALL MEMBERS ARE URGED TO USE THE MARYLAND AVENUE ENTRANCE AND EXIT FROM 9:00 A.M. TO 6:00 P.M.

ANNUAL MEETING *Speakers*

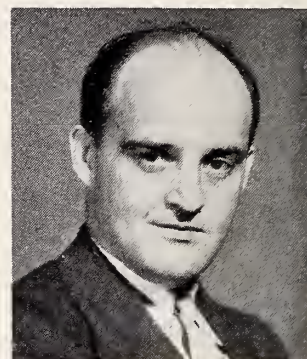


ALAN M. CHESNEY, M.D., the President of the Medical and Chirurgical Faculty, will give his Presidential Address, "Medical Education and Medical Research are Part and Parcel of the Medical Profession," at the Annual Meeting on Tuesday evening, April 29, 1952.

Dr. Chesney has been Dean since 1929 of The School of Medicine of The Johns Hopkins University. He was Managing Editor of "Medicine" from 1923 to 1947, and President of the Association of American Medical Colleges 1937-1938. Dr. Chesney is the author of "Immunity in Syphilis," published in 1929; "The Flowering of an Idea," published in 1939; "The Johns Hopkins Hospital and The Johns Hopkins University School of Medicine—A Chronicle," published in 1943.

OSLER A. ABBOTT, M.D., F.A.C.S., F.C.C.P., will give the John M. T. Finney Fund Lecture April 30, 1952 at 11:30 a.m. His subject will be, "The Recent Advances in Surgery of the Autonomic Nervous System." Dr. Abbott has been Assistant Professor of Thoracic Surgery at Emory University School of Medicine, Emory, Georgia, since 1947. He is Chief, Division Thoracic Surgery, Grady Memorial Hospital, Emory University Hospital; Consultant, Thoracic Surgery, Peachtree Veterans Administration Hospital, Lawson V.A. Hospital; and Consultant, Thoracic Surgery, Eggleston Hospital for Children.

Dr. Abbott was born in Hamilton, Ontario, Canada and he is a godson and great nephew of Sir William Osler. His father, the Right Reverend H. P. Almon Abbott, was the rector of Grace and St. Peter's Church in Baltimore from 1919 to 1929.



PAUL B. MAGNUSON, M.D., L.L.D., D.Sc., who is at present Chairman of the President's Commission on the Health Needs of the Nation, will give the I. Ridgeway Trimble Fund Lecture, on Wednesday evening, April 30, 1952 at our Annual Meeting. His topic will be, "Too Big a Job for One Year."

Dr. Magnuson is also Attending Surgeon, Passavant Memorial Hospital, Chicago; Senior Consulting Orthopaedic Surgeon, Wesley Memorial Hospital, Chicago; Professor of Surgery (Emeritus) and former Chairman, Department of Bone and Joint Surgery, Northwestern University Medical School, Chicago. Dr. Magnuson is the author of "Fractures," published in 1933; and "Section on Ununited Fractures, Orthopedic Subjects," National Research Council.

On Tuesday evening, April 29, 1952 DR. CORNELIUS P. RHOADS will give the I. Ridgeway Trimble Fund Lecture. His subject will be, "Recent Developments in Cancer Research." Dr. Rhoads is Director of the Memorial Center for Cancer and Allied Diseases; Professor of Pathology, Cornell University Medical College; Special Consultant, United States Public Health Service, National Advisory Cancer Council; and a member of the Committee on Atomic Bomb Casualties. Dr. Rhoads also is an authority on poliomyelitis, renal physiology, anemia, deficiency disease, diet in experimental cancer, clinical biochemistry of gastric and other cancer, and steroid metabolism in cancer.

SIR WILLIAM ALLEN DALEY, M.D., F.R.C.P., of London, England, will speak on Wednesday morning, April 30, 1952. His subject will be "The Relative Position of the Specialist, the General Practitioner, and the Public Health Officer in Britain." Sir Allen Daley for many years was Medical Officer of Health of the London County Council. Beginning March 1952 he will serve for four months, on a half-time basis, as Associate Health Officer of Baltimore City in the City Health Department. At the recent Annual Meeting of the American Public Health Association, he was elected an Honorary Fellow.

ERNEST B. HOWARD, M.D., Assistant Secretary of the American Medical Association, will participate in the panel discussion, "You and Your A.M.A.," on Tuesday morning, April 29, 1952. Dr. Howard received his M.D. degree from the Boston University School of Medicine, and Master of Public Health degree from the Harvard School of Public Health. He served as director of the Division of Venereal Disease Control, from 1940 to 1942 and as assistant director of the Army's V.D. Control program from 1942 to 1945. He was chosen as chief of the U. S. Department of State's health mission to Peru in 1946. He joined the A.M.A. as Assistant Secretary in April, 1948.

WALTER B. MARTIN, M.D., of Norfolk, Virginia, and a member of the Board of Trustees of the American Medical Association, will participate in the panel discussion, "You and Your A.M.A.," on Tuesday morning, April 29, 1952. Dr. Martin is a graduate of the School of Medicine of The Johns Hopkins University, and served an internship at the Johns Hopkins Hospital. He is Chief of Medical Service of the De Paul Hospital and Consultant in Internal Medicine of the United States Public Health Service Hospital in Norfolk.

Tuesday Morning Session, (continued)

3. A Case of Hemiballismus Before and After Surgery. (5 minutes.) Discussed by **George W. Smith, M.D.**

Produced in The School of Medicine of The University of Maryland.

4. Platybasia, Primary and Secondary. (5 minutes.) Discussed by **Charles Bagley, Jr., M.D.** and **George W. Smith, M.D.**

Produced in The School of Medicine of The University of Maryland.

SCIENTIFIC SESSION

ALAN M. CHESNEY, M. D., *President*, Presiding

- 10:00 a.m. Clinical Pathological Conference by The Staff of the School of Medicine of The University of Maryland. (Lantern slides.)

T. Nelson Carey, M.D., Professor of Clinical Medicine, School of Medicine, The University of Maryland.

C. Gardner Warner, M.D., Associate Professor of Pathology, School of Medicine, The University of Maryland.

YOU AND YOUR A.M.A.

- 11:00 a.m. (Lantern slides and motion pictures.)

Ernest B. Howard, M.D., Assistant Secretary of the American Medical Association.

Walter B. Martin, M.D., Member of Board of Trustees of the American Medical Association.

George H. Yeager, M.D., Secretary of the Medical and Chirurgical Faculty.

Question and Answer Period.

- 12:30 p.m. Adjournment.

OSLER HALL

(Entrance and Exit—Maryland Avenue)

Tuesday, April 29, 1952

Afternoon Session

R. CARMICHAEL TILGHMAN, M.D., *Vice-President*, Presiding

CONTRAINDICATIONS TO ACTH AND CORTISONE. (LANTERN SLIDES.)

- 2:30 p.m. Panel Discussion.

Moderator

Warde B. Allan, M.D., Associate Professor of Medicine, School of Medicine, The Johns Hopkins University.

Participants

A. McGehee Harvey, M.D., Professor of Medicine, School of Medicine, The Johns Hopkins University.

John C. Krantz, Jr., Ph.D., Professor of Pharmacology, School of Medicine, The University of Maryland.

- 4:30 p.m. Adjournment.

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- 4:30-5:00 p.m. Visit the Exhibits.

ALL MEMBERS ARE URGED TO USE THE MARYLAND AVENUE ENTRANCE AND EXIT FROM 9:00 A.M. TO 6:00 P.M.

Tuesday, April 29, 1952

EVENING MEETING

OSLER HALL

(Use Cathedral Street Entrance)

8:00 P.M.

Presiding ALAN M. CHESNEY, M.D., *President*

1. Medical Education and Medical Research are Part and Parcel of the Medical Profession. **Alan M. Chesney, M.D.**

PRESIDENTIAL ADDRESS

ABSTRACT. Medical education and medical research are part and parcel of the profession of medicine and must be taken into account in the consideration of any wide ranging proposals that affect the profession. Although medical education in this country is at the highest peak it has ever attained anywhere in the world, it is in jeopardy because of inadequate financial support of the medical schools on the one hand and shrinking clinical material for teaching purposes on the other. The reasons for this situation are discussed. While medical research is now liberally supported in the country, such support is available chiefly on a restricted basis through project grants. It should be made available in a more fluid form if the greatest benefits are to be achieved from the expenditure of the funds which are now at hand.

2. Recent Developments in Cancer Research. (Lantern slides.) **C. P. Rhoads, M.D.**, Director, Memorial Center for Cancer and Allied Diseases; Professor of Pathology, Cornell University Medical College, New York.

I. RIDGEWAY TRIMBLE FUND LECTURE

ABSTRACT. A general, and simplified concept of the cancer problem will be presented. A substantial research program ranging from the most fundamental to the most applied has been developed, based upon this concept. The advances which have been made under this program will be described with particular emphasis on the practical application today and to be expected in the future.

3. Necrology. **Frank J. Geraghty, M.D.**, Chairman, Memoir Committee. (The members are requested to remain standing during the reading of the report.)

NECROLOGY

BALTIMORE CITY

Beck, Harvey G.	October 30, 1951
Blake, Herbert C.	November 20, 1951
Cole, J. Wesley	January 19, 1952
Cotton, Albertus	May 3, 1951
Forsythe, Hugh	April 1950
Hibbitts, John T.	September 24, 1951
Homer, Harry L.	July 27, 1951
Knapp, Hubert C.	December 31, 1951
Knox, J. H. Mason, Jr.	December 31, 1951
Kroll, Louis J.	February 28, 1952
McConachie, Alexander Douglas	September 21, 1951
Onnen, John G.	April 18, 1951
Padget, Paul	October 31, 1951
Pearce, William H.	July 28, 1951
Ries, A. F.	January 3, 1952
Robertson, Fred S.	April 16, 1951
Schaefer, Theodore A.	January 9, 1952
Sudler, Wright S.	November 20, 1951
Wallenstein, Sydney	August 29, 1951
White, Thomas S.	March 6, 1952

ALLEGANY-GARRETT COUNTY

Gracie, W. A.	December 28, 1951
Owens, M. E. B., Sr.	December 6, 1951

ANNE ARUNDEL COUNTY

Hopkins, Walton H.	October 24, 1951
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BALTIMORE COUNTY

Jenifer, Daniel of St. Thomas	April 30, 1951
Sellman, Reginald Oliver	January 25, 1952

CARROLL COUNTY

Stewart, John Joseph	
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DORCHESTER COUNTY

Meredith, Lida O., Cambridge	March 7, 1952
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FREDERICK COUNTY

Roop, E. P.	February 3, 1952
Stone, Otis B.	January 5, 1952
Tyson, Robert S.	

KENT COUNTY

Burgard, Albert A.	October 17, 1951
Smith, Frank W.	July 16, 1951

MONTGOMERY COUNTY

Horgan, Joseph	November 12, 1951
Howlett, H. H.	January 19, 1952
Stull, H. Tuttle	December 18, 1951

ST. MARY'S COUNTY

Welch, Aloysius C.	June 13, 1951
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SOMERSET COUNTY

Lankford, Henry M.	October 7, 1951
Somers, Charles L.	April 13, 1951

EXHIBITORS

Prominent firms, dealing in books and supplies required by physicians, as listed below, will exhibit during the Annual Meeting of the Medical and Chirurgical Faculty.

Our thanks are extended to Hynson, Westcott & Dunning, Inc., who have kindly contributed to our Annual Meeting, although it was not convenient for them to exhibit this year.

We wish to express our appreciation to the Coca-Cola Bottling Company of Baltimore and the Seven-Up Bottling Company of Baltimore for the serving of free Coca-Cola and Seven-Up to members.

- | | |
|--|--|
| 1. A. S. Aloe Company | 17. The National Drug Company |
| 2. Doris Appel Medical Sculptures | 18. Ortho Pharmaceutical Corporation |
| 3. Beech-Nut Packing Company | 19. Parke, Davis & Company |
| 4. A. J. Buck & Son | 20. Charles Pfizer & Company, Inc. |
| 5. Coca-Cola Bottling Company of Baltimore | 21. Picker X-Ray Corporation |
| 6. Herbert Cox—Correct Shoes | 22. William P. Poythress & Company, Inc. |
| 7. Desitin Chemical Company | 23. A. H. Robins Company, Inc. |
| 8. Dictaphone Corporation | 24. W. B. Saunders Company |
| 9. The Doho Chemical Corporation | 25. G. D. Searle & Company |
| 10. General Electric X-Ray Corporation | 26. Seven-Up Bottling Company of Baltimore |
| 11. Graymar Company | 27. Similac Division, M & R Laboratories |
| 12. Kloman Instrument Company, Inc. | 28. The Upjohn Company |
| 13. The Liebel-Flarsheim Company | 29. U. S. Vitamin Corporation |
| 14. Eli Lilly & Company | 30. Walker Laboratories, Inc. |
| 15. Mead Johnson & Company | 31. Weinberg & Hinrichs |
| 16. Murray-Baumgartner Surgical Instrument Company, Inc. | 32. White Laboratories, Inc. |
| | 33. The Williams & Wilkins Company |

Exhibits will be open from 9:00 a.m. to 5:30 p.m.

SUBCOMMITTEE ON EXHIBITS

Committee on Scientific Work and Arrangements

Edwin H. Stewart, Jr., M.D., *Chairman*, Baltimore

Michael I. O'Connor, Baltimore

John A. Strevig, Phar.D., Baltimore

DO NOT FAIL

To Register with the Exhibitors!

Wednesday, April 30, 1952

8:00 a.m. to 12 noon. OPERATIONS POSTED

MEMBERS WELCOME

The Johns Hopkins Hospital, Schedule Posted—Halsted Lobby

The University Hospital, Schedule Posted—8th Floor Rotunda

Morning Session

9:00 a.m. Visit the Exhibits—Tent, Supper Room, and Basement Corridor.
Entrance on Maryland Avenue.

OSLER HALL

(Entrance and Exit—Maryland Avenue)

9:00 a.m. Motion Pictures.

1. Hemipelvectomy. (15 minutes.) Discussed by **Mark M. Ravitch, M.D.**
Produced in The Johns Hopkins Hospital and The School of Medicine of The Johns Hopkins University.
2. The Operative Treatment of Pectus Excavatum. (15 minutes.) Discussed by **Mark M. Ravitch, M.D.**
Produced in The Johns Hopkins Hospital and The School of Medicine of The Johns Hopkins University.
3. Esophagectomy. (15 minutes.) Discussed by **William F. Reinhoff, Jr., M.D.**
Produced in The Johns Hopkins Hospital and The School of Medicine of The Johns Hopkins University.

SCIENTIFIC SESSION

FRANK J. GERAGHTY, M.D., *Vice-President*, Presiding

- 10:00 a.m. Clinical Pathological Conference by The Staff of The School of Medicine of The Johns Hopkins University. (Lantern slides.)
Charles W. Wainwright, M.D., Associate Professor of Medicine, School of Medicine, The Johns Hopkins University.
Morgan Berthrong, M.D., Assistant Professor of Pathology, School of Medicine, The Johns Hopkins University. (By invitation.)
- 11:00 a.m. The Relative Position of the Specialist, the General Practitioner, and the Public Health Officer in Britain.
Sir Allen Daley, M.D., F.R.C.P., Formerly Medical Officer of Health of the London County Council. Associate Health Officer of Baltimore City Health Department, March to June 1952.

(Continued on next page)

SEE THE CREATIVE ARTS SHOW

Second Floor, Frick Reading Room

Visit the A.M.A. Exhibits—Main Floor Corridor

Wednesday Morning Session, (continued)

11:30 a.m. The Recent Advances in Surgery of the Autonomic Nervous System. (Lantern slides and motion picture film.)

Osler A. Abbott, M.D., F.A.C.S., F.C.C.P., Assistant Professor of Clinical Surgery (Thoracic); Chief, Division of Thoracic Surgery, Emory University School of Medicine, Emory, Georgia.

JOHN M. T. FINNEY FUND LECTURE

ABSTRACT. This lecture is concerned with the present status of surgery of the autonomic nervous system. Brief reference is made to the knowledge relative to the physiology of the autonomic nervous system in regard to the symptom complexes for which autonomic nerve surgery is at present being utilized. The over-all experiences of the Emory University Clinics with surgery of the autonomic nervous system are briefly summarized. Emphasis, in this lecture, is placed upon the application of various forms of autonomic nerve surgery to diseases of the thoracic viscera. A fairly extensive experience has been achieved with such surgery in regard to bronchial asthma, angina pectoris, irresectable coarctation of the aorta, thoracic aortic aneurysms, intractable paroxysmal auricular tachycardia, recurrent spontaneous pneumothorax and pulmonary emphysema.

A limited number of objective clinical respiratory physiological studies have been carried out in this patient group. The results of these studies are described. Particular reference is placed upon the role of these studies in the evaluation of such patients as candidates for autonomic surgery. Further extensive clinical research is still required before one can finally determine the exact value of this therapeutic approach to diseases of the thoracic viscera.

12:30 p.m. **ELECTION OF THE BOARD OF MEDICAL EXAMINERS.**

12:45 p.m. Adjournment.

OSLER HALL

(Entrance and Exit—Maryland Avenue)

Wednesday, April 30, 1952

Afternoon Session

MOSES S. SHILING, M.D., Presiding

**SYMPOSIUM ON THE TUBERCULOSIS PROBLEM IN BALTIMORE—Past,
Present and Future**

2:00 p.m. Panel Discussion.

Moderator

JOHN T. BARNWELL, M.D., Chief, Tuberculosis Division, Veterans
Administration, Washington, D.C.

The total problem of tuberculosis in Baltimore will be discussed as seen by the general practitioner, phthisiologist, epidemiologist, chest surgeon, psychiatrist, nurse, health department, sanatorium, general hospital and the medical school.

4:30 p.m. Adjournment.

Wednesday, April 30, 1952

6:30 P.M.—7:30 P.M.

BUFFET SUPPER

1211 Cathedral Street

Reservations, accompanied by check, must be made prior to Thursday, April 24, 1952

Cover charge—\$4.50 per person

The members are urged to bring their wives and guests to the Buffet Supper. A cordial invitation is extended to EVERYONE to attend the evening meeting.

GENERAL MEETING

OSLER HALL

(Use Cathedral Street Entrance)

- Presiding.....Alan M. Chesney, M.D., *President*
1. Introduction of **Mrs. George H. Yeager**, President, Woman's Auxiliary to the Medical and Chirurgical Faculty.
 2. Too Big a Job for One Year. **Paul B. Magnuson, M.D., L.L.D., D.Sc.**, Chairman of the President's Commission on the Health Needs of the Nation, Washington, D.C., and Chicago, Illinois.

I. RIDGEWAY TRIMBLE FUND LECTURE

An Acknowledgment

The members of the Medical and Chirurgical Faculty wish to thank the Committee on Scientific Work and Arrangements, Dr. Beverley C. Compton, *Chairman*, Dr. William L. Garlick, and Dr. Edwin H. Stewart, Jr., for their untiring efforts and giving of their time to plan and organize this Annual Meeting.

THIRD ANNUAL MEETING OF THE WOMAN'S AUXILIARY TO THE MEDICAL
AND CHIRURGICAL FACULTY

Headquarters—Stafford Hotel

Baltimore

WEDNESDAY, APRIL 30, 1952

MRS. THOMAS A. CHRISTENSEN, Chairman of Arrangements

President—MRS. GEORGE H. YEAGER

Corresponding Secretary—MRS. LEWIS P. GUNDRY

Treasurer—MRS. PAGE C. JETT

Recording Secretary—MRS. H. VINCENT DAVIS

Registration—Commencing 11 a.m.

Presiding—MRS. GEORGE H. YEAGER, PRESIDENT

10 a.m. to 11 a.m. Preconvention Board Meeting.

11 a.m. to 12 noon Showing of Exhibits which are available for Auxiliary "Health Booths" at County Fairs.

Round Table on Auxiliary Work. Moderators—State Auxiliary Chairmen and Officers.

"Frontiers in Medical Research." Motion picture, courtesy of Maryland Society for Medical Research

"Girls in White." Motion picture, courtesy of A.M.A.

Exhibit on "Quackery," courtesy of A.M.A.

12 noon to 1 p.m. Business Meeting.

1 p.m. to 2:45 p.m. * Luncheon, Lecture and Fashion Show.

Medicine and the Bible. **Louis Krause, M.D.**

2:45 p.m. to 3 p.m. Election of Officers.

3:00 p.m. Adjournment of General Session.

3:00 p.m. to 3:30 p.m. Post Convention Board Meeting.

COMMITTEE ON ARRANGEMENTS. Mrs. Thomas A. Christensen, *Chairman*; Mrs. George G. Finney, *Decorations*; Mrs. M. Elliott Randolph, *Fashion Show*; Mrs. Louis Charles Dobihal, *Hospitality*; Mrs. R. Walter Graham, Jr., *Tickets*; Mrs. A. E. Goldstein, *Publicity*; Mrs. Emil G. Bauresfeld, *Finance*.

* As Dr. Krause's address will be of interest to all, the husbands of the members of the Auxiliary are invited to luncheon, which will start promptly at 1:00 p.m., and will last one hour.

WARNING TO AUXILIARY MEMBERS

The Constitution of the Woman's Auxiliary to the Medical and Chirurgical Faculty specifically states that it may endorse legislation in support of principles, but that it cannot back a candidate for public office. Membership lists cannot be used for political purposes!

CREATIVE ARTS SHOW

Frick Reading Room, Library Floor

This show has been arranged and planned under the auspices of a Committee of the Woman's Auxiliary to the Medical and Chirurgical Faculty consisting of Mrs. Beverley C. Compton, Chairman, Mrs. Frank R. Smith, Co-Chairman, Mrs. Marius P. Johnson, Mrs. John W. Parsons, Mrs. Benjamin H. Rutledge, Mrs. Howard C. Smith, Mrs. I. Ridgeway Trimble, Mrs. Lawson Wilkins, and Mrs. Walter L. Winkenwerder.

Entries

Mrs. William R. Amberson, Cockeysville	Paintings
Mrs. Charles R. Austrian, Baltimore	Painting
Mrs. Edwin Kemp Ballard, Baltimore	Crocheted luncheon cloth and runner
Dr. Edwin Kemp Ballard, Baltimore	Picture
Dr. Margaret B. Ballard, Baltimore	Color Transparencies
Mrs. Charles E. Brambel, Baltimore	Decorated Chair
Dr. Howard M. Bubert, Baltimore	Photography
Mrs. H. Arthur Cantwell, North East	Painting
Dr. John Chandler Cobb, Baltimore	Painting
Dr. Elmer Ellsworth Cook, Baltimore	Oil Painting
Mrs. Houston S. Everett, Baltimore	Oil Painting
Mrs. A. Murray Fisher, Ruxton	Sculpture
Dr. Louis E. Goodman, Baltimore	Sculpture
Dr. Lyle L. Gordy, Baltimore	Oil Painting
Dr. Wilson Grubb, Baltimore	Gun conversion
Dr. Richard B. Hanchett, Baltimore	Painting
Dr. Louis E. Harmon, Baltimore	Photography
Dr. Gustav Highstein, Baltimore	Painting
Steven Highstein (son of Dr. Gustav Highstein)	Air Plane Model
Mrs. Guy L. Hunner, Baltimore	Hooked rug
Fay M. Johnson (Daughter of Dr. William R. Johnson) Baltimore	Weaving
Dr. B. L. Jones, Glen Burnie	Oil Painting
Dr. Ilse Kamm, Sykesville	Painting
Dr. and Mrs. Eugene Kester, Rock Hall	Photography
Mrs. George A. Knipp, Baltimore	Needlepoint
Elizabeth Knotts Davison, Denton (Daughter of Dr. E. Paul Knotts)	Painting
Barbara Anne Machen, Baltimore (Daughter of Dr. John W. Machen)	Painting
Dr. John W. Machen, Baltimore	Painting
Dr. David I. Macht, Baltimore	Medical Research
Dr. Raymond L. Markley, Jr., Baltimore	Model car
Mrs. Lay Martin, Baltimore	Paintings
Dr. Lay Martin, Baltimore	Abstract
Dr. N. Edward Nachlas, Baltimore	Copper relief work
Mrs. Willard S. Parson, Halethorpe	China painting
Gay Parsons, Baltimore (Daughter of Dr. John W. Parsons)	Handmade figures
Mrs. John W. Parsons, Baltimore	Painting
Mrs. Howard H. Patt, Baltimore	Photography
Mrs. Morris B. Schreiber, Baltimore	Afghan
Dr. and Mrs. Edgar Roderick Shipley, Baltimore	Color transparencies
Dr. Merrell L. Stout, Baltimore	Photography
Dr. Benjamin Tappan, Baltimore	Photography and wood carving
Dr. Charles Luther Warner, Baltimore	Pastels
Mrs. William H. F. Warthen, Towson	Painted trays
Mrs. Walter L. Winkenwerder, Eccleston	Painting
Page Wroth Jamison, Hagerstown (Daughter of Dr. Peregrine Wroth)	Hooked rug
Mrs. George H. Yeager, Baltimore	Painting

Business Sessions

Annual Meeting

COUNCIL

Monday, April 28, 1952, 11 a.m.

Friedenwald Room

Tuesday, April 29, 1952, 1:30 p.m.

Friedenwald Room

MEMBERSHIP OF THE COUNCIL

	<i>Term Expires</i>		<i>Term Expires</i>
C. REID EDWARDS, <i>Chairman</i> , Baltimore	1953	WILLIAM D. NOBLE, Easton	1954
MAURICE C. PINCOFFS, <i>Vice-Chairman</i> , Baltimore	1952	PALMER F. C. WILLIAMS, Pikesville	1954
CHARLES R. AUSTRIAN, Baltimore	1952	ALAN M. CHESNEY, <i>President</i> , Baltimore	1952
JOHN M. T. FINNEY, Jr., Baltimore	1952	GEORGE H. YEAGER, <i>Secretary</i> , Baltimore	1952
WILLIAM B. LONG, Salisbury	1952	J. ALBERT CHATARD, <i>Treasurer</i> , Baltimore	1952
O. H. BINKLEY, Hagerstown	1953	EVERETT S. DIGGS, <i>Assistant Secretary</i> , Baltimore	1952
JAMES T. MARSH, Westminster	1953	WALTER D. WISE, <i>Past President</i> , Baltimore	1952
W. O. McLANE, Frostburg	1953	President-elect	1952
E. COWLES ANDRUS, Baltimore	1954	LOUIS KRAUSE, <i>Chairman of the Library Committee</i> , Baltimore	1955
THOMAS A. CHRISTENSEN, College Park	1954	WARDE B. ALLAN, <i>A.M.A. Delegate</i> , Baltimore	1952
MONTÉ EDWARDS, Baltimore	1954	J. W. BIRD, <i>A.M.A. Delegate</i> , Sandy Spring	1953
WARFIELD M. FIROR, Baltimore	1954	JOHN W. PARSONS, <i>A.M.A. Delegate</i> , Baltimore	1953
WHITMER B. FIROR, Baltimore	1954		

CHRONOLOGICAL OUTLINE OF THE BUSINESS SESSIONS

Monday, April 28, 1952

Council, Friedenwald Room, 11:00 a.m.

Luncheon, Osler Hall, 1:00 p.m.

House of Delegates, Small Hall, 2:00 p.m.

Tuesday, April 29, 1952

Council, Friedenwald Room, 1:30 p.m.

House of Delegates, Small Hall, 2:00 p.m.

Wednesday, April 30, 1952

House of Delegates, Small Hall, 9:30 a.m.

ALL MEMBERS ARE URGED TO USE THE MARYLAND AVENUE ENTRANCE AND EXIT FROM 9:00 A.M. TO 6:00 P.M.

HOUSE OF DELEGATES

Membership

The House of Delegates is composed of the delegates of the Component Societies as listed; the members of the Council; and the following *ex officio* members:

ALAN M. CHESNEY, *President*
GEORGE H. YEAGER, *Secretary*
J. ALBERT CHATARD, *Treasurer*
WALTER D. WISE, *Immediate Past President*
President-Elect
LEWIS P. GUNDRY, *Board of Medical Examiners*
WARDE B. ALLAN, *Delegate to the American Medical Association*
J. W. BIRD, *Delegate to the American Medical Association*
JOHN W. PARSONS, *Delegate to the American Medical Association*
LOUIS KRAUSE, CHAIRMAN, *Library Committee*

The meetings of the House of Delegates are open to all members but the privileges of the floor are for delegates only. If they so desire, members of the House of Delegates may ask the chairmen of the committees for elucidation of their reports.

The House of Delegates will meet in the Small Hall of the Faculty Building, 1211 Cathedral Street, and the Special Meeting was called by the President, Dr. Alan M. Chesney, (Article VIII, Section 2, Constitution) for Monday, April 28, 1952, at 2 p.m. This has been done in order to shorten the first regular session and make it possible for the delegates, officers, councilors and chairmen of committees to attend the scientific meetings.

Luncheon will be served to the Chairmen of Committees and the members of the Council and House of Delegates at 1:00 p.m. on Monday, April 28th in Osler Hall, 1211 Cathedral Street.

SPECIAL SESSION

Monday, April 28, 1952, 2:00 P.M., Small Hall

ALAN M. CHESNEY, M.D., *President*, Presiding

- I. Call to order.
- II. Registration of delegates.
- III. Reading of minutes.
- IV. Reports of officers and committees. (The summary of the reports has been mailed to every member of the House of Delegates.)
 1. Secretary.
 2. Treasurer.
 3. Council.
 4. Delegates to the American Medical Association.
 5. Board of Medical Examiners.
 6. Library Committee and Finney Fund Committee.
 7. Committee on Scientific Work and Arrangements.
 8. Professional Conduct Committee.
 9. Editor, Maryland State Medical Journal.
 10. Maternal and Child Welfare Committee.
 11. Memoir Committee.
 12. Eugene Fauntleroy Cordell Fund Committee.
 13. Legislative Committee.
 14. Committee on Medical Research.
 15. Cancer Committee.
 16. Committee on Public Instruction.
 17. Army Medical Library Committee.
 18. Committee on Industrial Health.
 19. Physiotherapy Committee.
 20. Committee to Advise the State Industrial Accident Commission.
 21. Tuberculosis Committee.
 22. Committee on Medical Service and Public Relations.
 23. Mental Hygiene Committee.
 24. Committee on Rural Medicine.
 25. Committee on the Constitution and By-Laws.
 26. Committee on National Emergency Medical Service.
 27. Blood Bank Advisory Committee.
 28. Medical Care Campaign Committee.
 - a. Speakers Bureau.
 29. Sesquicentennial Committee (New Building).
 - a. Finance Committee.
 - b. Building Plans Committee.
 30. Postgraduate Educational Committee.
 31. Diabetic Detection Committee.
 32. Scientific Speakers Bureau.
 33. Advisory Committee to the Woman's Auxiliary.
 34. Committee to Consider the Relationship between Hospitals and Specialties and the Manner of Payment for Professional Services.
 35. Committee for the Study of Pelvic Cancer.
 36. Committee for the Study of Certain Phases of Medical Economics.
 37. Joint Committee with the Bar Association on Medical Problems.
 38. Committee to Cooperate with the American Medical Education Foundation.

HOUSE OF DELEGATES

(THE MEETINGS OF THE HOUSE OF DELEGATES ARE OPEN TO ALL MEMBERS, BUT THE PRIVILEGES OF THE FLOOR ARE FOR DELEGATES ONLY.)

The meetings will be in the SMALL HALL, MEDICAL AND CHIRURGICAL FACULTY BUILDING, Tuesday, April 29, and Wednesday, April 30, 1952.

The President, Dr. Alan M. Chesney, will call the House to order and the following will constitute the order of business:

FIRST SESSION

Tuesday, April 29, 1952, 2:00 P.M.

- | | |
|--------------------------------|--------------------------|
| I. Call to order. | III. Reading of minutes. |
| II. Registration of delegates. | IV. New business. |

Constructive Recess

SECOND SESSION

- I. Nomination of officers, councilors, delegates to A.M.A., and committees, and recommendation to General Meeting for the Board of Medical Examiners. (See "Nominations" below)

THIRD SESSION

Wednesday, April 30, 1952, 9:30 A.M.

- | | |
|--------------------------------|-------------------------------------|
| I. Call to order. | IV. Election of officers. |
| II. Registration of delegates. | V. Unfinished business. |
| III. Reading of minutes. | VI. New and miscellaneous business. |

NOMINATIONS FOR 1953

<i>President</i>	MAURICE C. PINCOFFS, Baltimore
<i>Vice-Presidents</i>	{ GEORGE O. EATON, Baltimore OSBORNE D. CHRISTENSEN, Salisbury WILLIAM F. WILLIAMS, Cumberland (Also to fill unexpired term of Dr. W. A. Gracie, 1952 deceased)
<i>Secretary</i>	GEORGE H. YEAGER, Baltimore
<i>Treasurer</i>	J. ALBERT CHATARD, Baltimore
<i>Councilors</i>	{ CHARLES R. AUSTRIAN, Baltimore (1955) HUGH J. JEWETT, Baltimore (1955) WILLIAM B. LONG, Salisbury (1955) WALTER D. WISE, Baltimore (1955)
Delegate to American Medical Association.....	WARDE B. ALLAN, Baltimore (1953, 1954)
Alternate Delegate to American Medical Association.....	LOUIS H. DOUGLASS, Baltimore (1953, 1954)
Committee on Scientific Work and Arrangements.....	{ BEVERLEY C. COMPTON, Baltimore, <i>Chairman</i> WILLIAM L. GARLICK, Baltimore EDWIN H. STEWART, JR., Baltimore
Library Committee.....	WILLIAM K. DIEHL, Baltimore (1957)
Finney Fund Committee.....	I. RIDGEWAY TRIMBLE, Baltimore (1957)
Board of Medical Examiners.....	{ EDWARD M. HANRAHAN, JR., Baltimore (1956) JOHN E. LEGGE, Baltimore (1956)

Nominating Committee

- | | |
|--|-----------------------------|
| J. Mason Hundley, Jr., <i>Chairman</i> , Baltimore | |
| J. Tyler Baker, Easton | Simon Brager, Baltimore |
| E. I. Baumgartner, Oakland | Edward F. Cotter, Baltimore |

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

	<i>Term Expires</i>		<i>Term Expires</i>
<i>Delegate</i> —WARDE B. ALLAN, Baltimore; <i>Alternate</i> ,		<i>Delegate</i> —J. W. BIRD, Sandy Spring; <i>Alternate</i> , T.	
LOUIS H. DOUGLASS, Baltimore.....	1952	NELSON CAREY, Baltimore.....	1953
<i>Delegate</i> —JOHN W. PARSONS, Baltimore; <i>Alternate</i> ,			
BENJAMIN S. RICH, Baltimore.....	1953		

MEMBERS OF THE BOARD OF MEDICAL EXAMINERS

	<i>Term Expires</i>		<i>Term Expires</i>
ERASMUS H. KLOMAN, <i>President</i> , Baltimore.....	1955	HENRY T. COLLENBERG, Baltimore.....	1953
LEWIS P. GUNDRY, <i>Secretary-Treasurer</i> , Baltimore..	1954	E. PAUL KNOTTS, Denton.....	1953
EDWARD M. HANRAHAN, Baltimore.....	1952	EDWARD P. THOMAS, Frederick.....	1954
JOHN E. LEGGE, Baltimore.....	1952	JOHN H. HORNBAKER, Hagerstown.....	1955

ELECTED COMMITTEES

COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS

BEVERLEY C. COMPTON, *Chairman*, Baltimore
 WILLIAM L. GARLICK, Baltimore
 EDWIN H. STEWART, JR., Baltimore

LIBRARY COMMITTEE

	<i>Term Expires</i>
LOUIS KRAUSE, <i>Chairman</i> , Baltimore.....	1955
LAWRENCE R. WHARTON, Baltimore.....	1952
SAMUEL WOLMAN, Baltimore.....	1953
JOHN T. KING, Baltimore.....	1954
A. AUSTIN PEARRE, Frederick.....	1956
C. CLIFTON COWARD, D.D.S., Baltimore	

FINNEY FUND COMMITTEE

	<i>Term Expires</i>
SAMUEL McLANAHAN, <i>Senior Member</i> , Baltimore..	1952
DOUGLAS H. STONE, Baltimore.....	1953
HENRY M. THOMAS, Baltimore.....	1954
JOHN M. T. FINNEY, JR., Baltimore.....	1955
LOUIS P. HAMBURGER, Baltimore.....	1956

Professional Conduct Committee

Authorized by the House of Delegates April 24, 1950, and consists of five immediate Past Presidents and Chairman of the Council, with the Chairman of the Council as Chairman.

C. Reid Edwards, *Chairman*, Baltimore
 Walter D. Wise, Past President (1951), Baltimore
 A. Austin Pearre, Past President (1950), Frederick
 W. Houston Toulson, Past President (1949), Baltimore
 Charles W. Maxson, Past President (1948), Baltimore
 William T. Hammond, Past President (1947), Easton
 Alan M. Chesney, ex officio, Baltimore
 George H. Yeager, ex officio, Baltimore
 J. Albert Chatard, ex officio, Baltimore
 Everett S. Diggs, ex officio, Baltimore

Officers and Delegates of Component Societies

Baltimore City

1211 Cathedral Street
Baltimore 1, Maryland

President—SAMUEL McLANAHAN
Vice-President—WETHERBEE FORT

Secretary—EDWARD F. COTTER
Treasurer—J. ALBERT CHATARD

Journal Representative—EDWARD F. COTTER
1951-1952

Delegates

THURSTON R. ADAMS
T. NELSON CAREY
RICHARD G. COBLENTZ
WALTER E. GREMPER
GEORGE O. EATON
HOUSTON S. EVERETT
A. McGEHEE HARVEY
HUGH J. JEWETT
JOSEPH W. KETZKY
CHARLES F. MOHR
FRANCIS F. SCHWENTKER
RALPH P. TRUITT

Alternates

CONRAD ACTON
WILSON GRUBB
JOHN M. HAWS
EDMUND R. NOVAK
HARRY F. KLINEFELTER
FRANK J. OTENASEK
THOMAS R. O'ROURK
THEODORE E. WOODWARD
JOHN S. FENBY
JOHN E. SAVAGE
ZACHARIAH R. MORGAN
W. KENNEDY WALLER

1952-1953

Delegates

HELEN BOWIE
FERDINAND E. CHATARD, IV
WILLIAM E. GILMORE
ROBERT F. HEALY
JAMES R. KARNS
J. H. MASON KNOX, III
FRANKLIN E. LESLIE
F. FORD LOCKER
HUGH B. McNALLY
W. KENNETH MANSFIELD
H. WILLIAM PRIMAKOFF
W. H. TOWNSHEND, JR.

Alternates

I. WILLIAM NACHLAS
DOUGLAS H. STONE
HERBERT E. WILGIS
CECIL H. BAGLEY
WEBSTER H. BROWN
KATHERINE H. BORKOVICH
JOSEPH G. BIRD
NEWLAND E. DAY
WALTER S. NIBLETT
NATHAN E. NEEDLE
LESTER A. WALL, JR.
DANIEL J. PESSAGNO

Meetings—third Friday each month, October through April

SEE THE CREATIVE ARTS SHOW
Second Floor, Frick Reading Room

Visit the A.M.A. Exhibits—Main Floor Corridor

ALL MEMBERS ARE URGED TO USE THE MARYLAND AVENUE ENTRANCE AND EXIT FROM 9:00 A.M. TO 6:00 P.M.

Allegany-Garrett County

President—EMMETT L. JONES, JR., Cumberland

Vice-President—W. ROYCE HODGES, JR., Cumberland

Secretary—R. RHETT RATHBONE, Cumberland

Treasurer—LELAND B. RANSON, Cumberland

Delegates—JOHN K. ROZUM, Cumberland

JAMES T. JOHNSON, JR., Cumberland

Alternate—HILDA JANE WALTERS, Frostburg

BENEDICT SKITARELIC, Cumberland

Journal Representative—Leslie E. Daugherty, Cumberland

Meetings—Third Friday each month, usually at the Ali Ghan Shrine Club

Anne Arundel County

President—GEORGE C. BASIL, Annapolis

Vice-President—IRVING L. OCHS, Annapolis

Secretary—JESSE L. WILKINS, Annapolis

Treasurer—J. HOWARD BEARD, Annapolis

Delegate—DONALD HOOKER, Annapolis

Alternate—RANDALL McLAUGHLIN, Pasadena

Journal Representative—GEORGE C. BASIL, Annapolis

Meetings—Usually in January, April, July, and October

Baltimore County

President—CHARLES H. WILLIAMS, Pikesville

Vice-President—CHARLES F. O'DONNELL, Towson

Secretary-Treasurer—THOMAS E. WHEELER, Randalls-town

Journal Representative—THOMAS E. WHEELER, Randalls-town

Delegates—DAVID H. ANDREW, Baltimore

Melvin B. Davis, Dundalk

James G. Howell, Catonsville

Alternates—Martin Strobel, Reisterstown

Harry G. Butler, Owings Mills

William K. Gallager, Catonsville

Meetings—Third Wednesday in each month

Calvert County

President—ROBERTO DE VILLARREAL, Prince Frederick

Vice-President—EARL S. COSTER, Solomons

Secretary-Treasurer—PAGE C. JETT, Prince Frederick

Delegate—HUGH W. WARD, OWINGS

Alternate—GEORGE J. WEEMS, Huntingtown

Journal Representative—PAGE C. JETT, Prince Frederick

Meetings—First Tuesday in December to elect officers, other meetings on call

Caroline County

President—JAMES F. WRIGHT, Denton

Vice-President—CHARLES H. WINNACOTT, Ridgely

Secretary-Treasurer—ROBERT WRIGHT, GREENSBORO

Delegate—HAROLD B. PLUMMER, Preston

Alternate—F. M. ANDERSON, Federalsburg

Journal Representative—ROBERT WRIGHT, Greensboro

Meetings—On call, also meet with Upper Eastern Shore Medical Association

Carroll County

President—W. C. JENNETTE, Westminster

Vice-President—MERRITT ROBERTSON, New Windsor

Secretary-Treasurer—W. H. FOARD, Manchester

Delegate—M. C. PORTERFIELD, Hampstead

Alternate—ROBERT E. GARDNER, Sykesville

Journal Representative—W. H. FOARD, Manchester

Meetings—Third Wednesday of every other month except July and August

Cecil County

President—SEYMOUR GOLDGRABEN, Perry Point

Vice-President—S. RALPH ANDREWS, Elkton

Secretary-Treasurer—RICHARD C. DODSON, Rising Sun

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Meetings—Third Wednesday of every month, except June, July and August, at Union Hospital, Elkton, Maryland

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Meetings—Second Thursday of each month from September to June at 8:30 p.m., in the Jarwood Clinic, La Plata, Maryland

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Meetings—Third Tuesday in every month—except July and August

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Meetings—3rd Sunday of every second month beginning in January

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Meetings—Fourth Friday of every other month, beginning January

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Meetings—Third Tuesday of each month

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Journal Representative—SAMUEL J. N. SUGAR, Mt. Rainier

Meetings—1st Tuesday each month

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Journal Representative—G. WILLIAM MARTIN, JR., Queenstown

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Meetings—First Tuesday of each month, meeting with Staff of St. Mary's Hospital

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One regular meeting in December; meet w'ith Upper Eastern Shore Society (Talbot, Kent, Queen Anne's and Caroline) four times a year, once in each County. Meets in Talbot County in October

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Journal Representative—W. D. CAMPBELL, Hagerstown

Meetings—First Friday in January, April, July and October

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Meetings—Second Monday monthly

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Meetings—4th Wednesday of 3rd month, January, April, July and October

HONOR ROLL

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Caroline County

Cecil County

Charles County

Dorchester County

Howard County

Kent County

Queen Anne's County

St. Mary's County

Somerset County

Talbot County

Wicomico County

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CHARLES A. WATERS, Baltimore
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YOUR VOTE IS VITAL!

Whatever Your Party—REGISTER!

Whoever Your Choice—VOTE!

Scientific Papers

PAST—PRESENT—FUTURE*

J. ALBERT CHATARD, M.D.

Do we as modern members of our State Association really appreciate our historical background, and what the Faculty has accomplished by regulating the practice of medicine in the proper way for many years, through many Legislative difficulties?

In listing the names of those who stand out in this work and their support of the State Society, I will mention only a few: Doctors Osler, Welch, Tiffany, Harlan, Birnie, Ellis, Goldsborough, Trimble and Ruhräh, but there were a host of others.

The past is always interesting, not only from an historical point of view, but also because of its influence on the present and future. Those of you who have in your library a copy of Cordell's Annals should read it and thereby look into the first hundred years of our past. The book gives a comprehensive picture from the founding of the Faculty up to 1899, and the wonderful work done by our members throughout the State and City.

An address by Dr. Randolph Winslow in 1925, entitled, "Recollections of Fifty Years of the Medical and Chirurgical Faculty," contains the names of many old members - - our forebears from whom we have learned so much.

Dr. Thomas Cullen, in 1927, in his Presidential Address, "Early Medicine in Maryland," gives us a delightful historical picture of the old Society.

Another source of information open to all who wish to have more knowledge of its history, is

the Centennial Volume of the Library, from 1830 to 1930. A special tribute should be paid Miss Marcia C. Noyes, whose labor over many years cannot be forgotten or sufficiently praised. It gives me a great deal of pleasure to look back on the celebration which we had in her honor, just a short while before her death.

Finally, we have the Sesquicentennial Volume, which was available to all members during our meeting in April, last year. Dr. R. Carmichael Tilghman and Dr. J. C. French have compiled a delightful story of the history of the Faculty, particularly in bridging over the fifty years since Cordell's Annals.

It is unfortunate that every doctor could not have lived in more or less contact with Osler, and to know how much he accomplished during his fifteen years in Baltimore. Those fifteen years brought fruit to our Faculty and Library. To those of us who wish to think back and read more about his work, the "Medical Bible" which he left with us under the name "Aequanimitas and Other Addresses,"† must not be forgotten. I tried, in a very humble way in my Presidential Address in 1933 to pay tribute to him, and now again I call the attention of everyone to the importance of his many addresses and especially the book I have called, "The Physician's Bible."

John Ruhräh was another former member of the Faculty whose work for us can never be forgotten. He served through many official positions especially connected with the building up of the Library. The welfare of the Society

* I. Ridgeway Trimble Lectureship presented at the Annual Meeting of the Medical and Chirurgical Faculty, April 26, 1950.

† Aequanimitas, with other addresses to medical students, nurses and practitioners of medicine. Phila., P. Blakiston's Son and Co., 1904.

was always in his mind; so much so, that he left us a wonderful financial legacy which will help much in our future growth.

The late Dr. Harry Friedenwald was a prodigious worker for the Library. Because of close contact with him over many years, I cannot speak too feelingly about what he did for us. I must mention an activity of the Library in which he showed so much interest; The Book and Journal Club, later the Osler Historical Club. This Club was founded in 1896, at Dr. Osler's home, with Dr. Osler as the first President, and Dr. Friedenwald as the first Secretary. (This old minute book is carefully guarded in our archives and can be seen at any time. It holds information of great interest to all.) There were ten members at the first meeting, when it was decided to use funds obtainable from the Club for the purchase of new books and journals for the Faculty Library. The membership in this Club was voluntary and the dues were fixed at \$5.00 for each member, which was separate from Faculty dues. It was not long before the membership was about one hundred. Meetings were held on the third Tuesdays of November, January and March, at which time papers of historical interest were read, followed by a simple smoker. Dues were discontinued after 1922, but the meetings continued and in 1928, the name was changed to the Osler Historical Society, as a tribute to Dr. Osler. It was continued as such until 1940 at which time it was felt that the historical subjects were being well taken care of in other meetings. Having been closely connected as an officer for twenty years in this old Faculty Club, I know how it served its purpose in both a financial and cultural way. Over the twenty-five years of its existence, the Book and Journal Club collected from its members about \$10,000, all of which helped in the purchase of books and Journals. In addition many delightful and interesting papers were presented by local members as well as invited guests.

This old Faculty has had a wonderful inheri-

tance bequeathed to it. It shows such mellowing growth over 150 years that I have great hopes for progress in the future.

Can we help but be proud of our inheritance? Men were giants in their work in those days. The best that goes to make a doctor was there in abundance. Medicine was practiced as an art, with a gradual adoption of scientific progress as it developed and became available to the practicing physician. Specialists as such, were in their infancy, and the general practitioner or family doctor, in his "adult bloom."

Leaving the past and coming into the present, has this "adult bloom" been properly nourished? Alas, not in the way this should have been done. The age of specializing has been wonderful; the advancements in therapy, marvelous; the span of life lengthened. The sufferings of many have been allayed or helped by new drugs, and the medical and surgical care of the sick is a wonderful achievement.

We are at present in the midst of trying times. A profession unjustly criticised and fighting back for its future. Your help is asked for; your constructive criticisms wanted, and above all, your support in getting back to the position we held for so many years in the hearts of our patients and the love and respect of our community. Have we deserved some of this? And will we do better in the future? What is that future? It rests with each and every one of us.

Having been a general practitioner for over forty-five years, can I presume to give a little advice about the future? Has the family doctor passed out of the "public mind"? In some ways, yes, and in some ways, no. Can we ever thank our forebears enough for this old "general practitioner"? In the city and country, and throughout the State, he has struggled for many years often handicapped by training, isolation and distance. He did his best in good or bad weather, and yet his recompense was small financially, but exceedingly great in the love and respect and admiration that all had for him. Babies, children, adults and the aged, always felt better

when they saw him. He might not be able to do much, but he gave all he had, as best expressed in the following quotation:

"I've seen him, when the frozen tempest beat,
Breast it as gayly as the birds that played
Upon the drifts: and through the deadly heat
That drove the fainting reapers to the shade,
Smiling he passed along,
Erect the good gray head, and on his lips a song.
"I've known him, too, by anguish chained abed,
Foresake his midnight pillow with a moan,
And meekly ride wherever Pity led
To heal a sorrow slighter than his own;
or rich or poor the same—
It mattered not: let any sorrow call, he came."*

To many of us, to be such a man has been denied. We have been weaned away from such a life, and have developed over a period of years into some special type of work, scientific or practical, both necessary in the advancement of medicine. The specialist is necessary in bringing forward from the scientific field practical applications to the patient. But have we as specialists, forgotten the human side of the application of all our new and modern ideas? Put yourself in the patient's place—he is sick and wants advice. It may or may not be urgent. Make certain that the urgency is not overlooked by you in or outside your office. It is all right to be *busy—but not too busy*. A short talk directly between the doctor and patient may help in the future course of the patient's attitude and others to the profession in general.

Has the placing of medicine in the class of business been good for us in our fight against socialized medicine? We, as general practitioners, often get the first sign of the rumbling of the earthquake that may later engulf us all. It is hard to put my ideas into the cold facts of "financial remuneration," but that is what I am trying to bring out. The struggle for life and the burden of expenses are heavy. Can they not be lightened in some way? The sick one has his or her burden, and the greater glory in

the past for our profession was the old saying, "the doctor gets paid last." Let us accept our burden with all the grace we can, and look forward to the future for the proper solution.

The Faculty, as well as the profession throughout the country, is in the midst of a great struggle. I may be an idealist, but I visualize that in the future every eligible physician, whether in the scientific field, or that of the general practitioner, will be a member of his County or City Society. That every county will have ample well-trained physicians, with a nearness to county hospitals, and that the "old family doctor" will be a modern type of "*general practitioner*," well trained but always within nearby help from the specialist and hospital. Thus by team work from the sick person and through the family doctor, specialist and hospital, that person will receive adequate medical care within his finances.

National "Compulsory Medical Insurance" is no answer to this picture. The answer is in our hands. The art and practice of medicine can do it and do it well. Some of our ideas and mode of work must change. All of us by giving up certain modern ideas that we have at present, and getting back to the older idea that "the patient comes first," will accomplish this purpose.

Before concluding, I wish to say a few words that come from my heart, to each and every one of you. I hope I have many friends among you. My love for the medical profession has been so deeply born in me by four generations of doctors, that I cannot see it affected in any way by our own shortcomings. I am terribly shocked by the low esteem our profession is held in by so many. Are we to blame? In some ways we have drifted away from our forebears, and forgotten the Hippocratic oath and its intents. Each and every one of us entering into the preparation for the study of medicine and its fulfillment in practice, should look on our future work as a "vocation," and not just a financial mode of life. Our "higher ideals" should always be thought of and considered; the struggle to succeed, looked on as a

* In honor of Dr. Wm. Shorb, Frederick County, Maryland, who practiced around Mt. St. Mary's about 1867.

test of our endurance; and our "goal" to better the "woes of humanity."

"We are here not to get all we can out of life for ourselves but to try and make the lives of others happier. . . . The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head. Often the best part of your work will have nothing to do with potions and powders but with the exercise of an influence of the strong upon the weak, of the righteous upon the wicked, of the wise upon the foolish. . . . Yours is a noble heritage, made so by no efforts of your own, but by the generations of men who have unselfishly sought to do the best they could for selfish humanity. Think not to light a light to shine before men that they may see your good works; contrariwise, you belong to the great army of quiet workers, . . . the members of which strive not, neither do they cry, nor are their voices heard in the streets, but to them is given the ministry of consolation in sorrow, need, and sickness. . . . To you the silent workers of the ranks, . . . is given the harder task of illustrating with your lives the Hippo-

cratic standards. . . . A humanity that will show in your daily life, tenderness and consideration to the weak, infinite pity to the suffering, and broad charity to all. A probity that will make you under all circumstances true to yourselves, true to your high calling, and true to your fellow men."*

With these ringing words, Osler gave us a way of life, he gave us the basis of the art and practice of medicine; in a few words, he gave us "Unity, Peace, Concord, and Optimism." He also left us the Master-Word, "Work," and the final word, "Charity." "Charity," I would say in its broadest sense, not as so many look on it; but in the sense of our relations to our friends, patients and associates; this virtue coupled with its sister, "Humility," I pass on hand in hand to you, as the solution, revealed in the glories of what was our past; as a help in what is our present struggle; and as a beacon light guiding us on to what should be our future medical "way of life."

* The Master-Word In Medicine. Dr. William Osler, University of Toronto, 1903.

It is to be regretted that the Faculty office is late in sending out the American Medical Association bills for dues. It is hoped that the members will pay promptly in order to insure their membership in the American Medical Association. Checks (dues \$25.00 per year) should be made *payable* to the American Medical Association and *mailed* to the Medical and Chirurgical Faculty, 1211 Cathedral Street, Baltimore 1.

Reports

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

ABSTRACT OF CASE DISCUSSIONS

The Committee for the Study of Pelvic Cancer meets the third Thursday of each month in the Small Hall of the Medical and Chirurgical Faculty Building.

Case No. I. M. S. White. Age 51. Married. Para 4. LMP June 1950. June 1951 began to have vaginal bleeding which was continuous, varying in amount. Consulted doctor A. No pelvic examination. Given a series of 20 injections. Excessive bleeding in August—in bed for one week—oral medication, injections. Bleeding continued. Referred to doctor B, November 1951—immediately referred to doctor C and hospitalized. Referred to second hospital for treatment. *Diagnosis:* Squamous cell carcinoma of cervix, grade 3, stage 3.

Chairman: A woman presenting herself with these symptoms should undoubtedly have had a pelvic examination. There was apparent loss of time here from June to November.

Committee member: When this patient was diagnosed she was classified stage 3. If sent in earlier the disease undoubtedly would not have been so far advanced. Studies have shown a 55% reduction in cure in cases delayed to this stage before treatment.

Visiting surgeon: The case re-emphasizes the point that we may spend too much time educating the laity and not enough educating the doctors.

Chairman: On the basis of the information we have, Case I, appears to be a case of physician delay. We regret that the physician who first saw this patient was unable to be present today.

Case II. C. J. Col. Age 36. Married. Para 3. Patient found to have diabetes in 1947—not controlled. Following menstruation in May 1951, continual bloody spotting. Consulted doctor A, May 1951—was not examined—douches prescribed. Also was given oral medication for hypertension. At first saw doctor every week—later at less frequent intervals. Patient found unconscious in home November 1951 (gas escaping from stove—accidental) and taken to hospital. In hospital for one week—diabetes controlled and diagnosis of cancer of the cervix was made. Referred to second hospital for

radium treatment. *Diagnosis:* Squamous cell carcinoma of cervix, I. C. stage II, early.

There was some discussion as to whether hypertension could be considered a factor in the vaginal bleeding in this case. It was the consensus that the hypertension did not constitute an adequate explanation for the bleeding.

Chairman: On the basis of our information, this again seems to be a case of physician delay. The physician who first saw the patient was invited to attend the meeting today but was unable to come.

Case III. L. C. Col. Age 49. Married. Para 1. May 1950, pain in back and side. Consulted doctor A—pelvic examination was made. Late July 1950, patient referred to hospital for biopsy to rule out cancer. Biopsy 8/3/50 showed a basal cell hyperactivity, cervix. Repeat biopsy requested. Second biopsy 8/16 showed epidermoid carcinoma of cervix, transitional cell type. Patient hospitalized. Modified Wertheim operation. *Diagnosis:* Epidermoid carcinoma, cervix uteri, spinal cell type, invasive.

Visiting surgeon: If it had been known pre-operatively that the carcinoma was invasive, this case would have been treated with radium. This might have been detected by sharp conization but this was not done.

Visiting physician: This patient was first seen by me on May 10th, 1950, complaining of back pain and pain in leg. P. H. showed contact of TB. No anti-leuetic therapy. No operations. X-ray of chest was negative. Examination showed an erosion on the cervix which bled easily and the uterus was enlarged. Scrappings were taken and sent to the State Health Department. The report came back “suspicious”. Patient was referred to the hospital for biopsy of the cervix.

Chairman: This seems to be a case where all of the correct things have been done. The doctor is certainly to be commended for detecting this early carcinoma when the only complaint was pain in the back and leg.

It was suggested that the Committee have a special classification for asymptomatic detected cases. This suggestion was adopted.

Chairman: This is certainly a case of no delay and will be classified as an asymptomatic detected case.

Case IV. L. S. White. Age 27. Married. Para 3. Beginning in July 1951, post-coital bleeding occasionally—premenstrual spotting—intermenstrual bleeding. October 1951, bleeding became continuous and profuse. Consulted doctor A—was bleeding profusely—internal examination not made—pt. given an injection and told she had “fibroids”. Saw doctor A three times in one week—given injections—did not return as she felt she had not been adequately examined. Went to hospital clinic November 1951—biopsy taken—cervix cauterized—packed. Rx. admit for work-up. Admitted to hospital five days later. Operations: Hysterectomy with pelvic lymphadenectomy, bilateral; bilateral salpingo-oophorectomy; appendectomy. *Diagnosis:* Adenocarcinoma of cervix, League of Nations I.

Chairman: Is there any discussion of this case?

Visiting physician: It would seem apparent that the patients do not always give the correct facts. According to my records this patient first consulted me on November 3, 1951 with complaint of bleeding off and on since July. Periods said to be normal to July 1951. She was bleeding rather freely at the time of visit. She refused to be examined. She was given an injection of estrogen. Patient returned on the 5th with bleeding checked but not sufficiently to be examined. She returned on the 6th and pelvic examination was made. Surgery was advised. The patient said she wished to discuss the matter with her husband. I have not seen or heard from her since.

Chairman: We are very grateful to you for coming to set us straight on some aspects of this case. This would seem to be a case of patient delay only, because there was a delay of only three days before a pelvic examination was made. The case does possibly bring up the question of examining a patient who is bleeding. There is some feeling that this should not be done. We feel that it should be done even though the patient is bleeding quite freely.

Visiting surgeon: This might again bring up the question of giving hormones to check bleeding. As has been emphasized before this may mask the symptoms so that the patient delays treatment until it is too late.

Chairman: In general it is a dangerous thing to do.

Is there any discussion of the treatment in this case?

Visiting surgeon: This case was considered suitable for operation as it was an early lesion, the patient

was thin, etc. It was a selected case. Also the first biopsy report in this case showed anaplastic carcinoma. The final diagnosis was adenocarcinoma but there was some discussion among the pathologists as to whether it was adeno or epidermoid. It is my feeling that adencarcinoma does better in some cases by surgery rather than irradiation.

Case V. M. R. White. Age 38. Married. Para 9. Beginning in late June or July 1951, menses q. 2 weeks—progressively profuse—considerable leucorrhea. Consulted doctor A, August 1951—was examined and referred to hospital clinic. Seen in this clinic 2-3 times—cervix cauterized—biopsy showed carcinoma. Referred to second hospital September 10, 1951, for treatment. Radium and x-ray. *Diagnosis:* Epidermoid carcinoma, cervix, I. C. Stage I.

Committee member: This case brings up a question which has already been discussed here two or three times—the question of doing a biopsy and cauterization at the same time. In this particular case the biopsy report got astray from the hospital history so that there was time lost before the diagnosis was known and the patient referred for treatment. I would like to add that in this hospital there is no cauterizing at the time of biopsying.

There was considerable discussion as to whether or not it is ever advisable to do a cauterization at the time a biopsy is taken.

Chairman: The conclusion seems to be to get a diagnosis before definitive treatment.

Committee member: There was probably a lapse of about five weeks from the time the patient was first seen in the dispensary until she was referred for treatment. On the basis of our decision to classify any time over a month as “delay”, this should be classified “institutional delay”.

Case VI. M. S. White. Age 52. Married. Menopause at 49 years. Profuse vaginal bleeding August 1950 for 3-4 days. Consulted doctor A—pelvic examination not done—was given oral medication and told vaginal bleeding “good for high blood pressure”. Advised patient to go to hospital clinic but did not urge this. Profuse vaginal bleeding did not recur until August 1951—but patient had intermittent episodes of post-coital bleeding. Patient brought to hospital accident room 9/23/51 bleeding profusely per vagina, in shock and complaining of substernal oppression. EKG revealed a severe anterior myocardial infarct—acute process. Upon the strong advice of the medical service no diagnostic procedure was done until 12/17/51 when cervical biopsy and Papanicolaou smears obtained. Radium 12/20/51. *Diagnosis:* Infiltrating immature squamous cell carcinoma of cervix, stage 3.

Visiting physician: My records show that I first saw this patient at her home on November 9th, 1948, with complaint of headache and pain in upper abdomen. B. P. at that time 240/130. The patient was very obese. She was put on a diet and advised as to her hypertension. Menstrual history at this time not revealed. The patient was next seen on April 13, 1949, with complaint of pain in upper right quadrant. B. P. 230/110. She had all the symptoms of gall bladder disease. She was again put on a diet and asked to come to the office for further examination. I did not see her again until April 16th, 1950, when called to her home. She was having profuse vaginal bleeding and gave a history of irregular periods for some time. A pelvic examination was not done at home but the patient was requested to come to the office for examination. She did not come. To reassure the patient I did make the remark quoted. The patient was not seen again until August of 1951 when she was having very profuse vaginal bleeding and I told her she would have to go to the hospital as soon as a bed was available. This patient did not come to the office as requested and pelvic examination was not done when I saw her at home.

Visiting surgeon: A brief abstract of the hospital record shows that the patient was first seen in the hospital accident room 9/24/51. Vaginal bleeding, present for the past six months, had become so profuse for the past five days that emergency admission was necessitated. At the time of admission the patient was in shock. Unsatisfactory pelvic examination at the time revealed a hard, brittle cervix with probably involvement of the left parametrium, but medical condition contra-indicated further manipulation. Diagnosis of shock, secondary to hemorrhage and possible coronary occlusion was made. The patient was transfused, packed, given oxygen therapy and admitted to the ward under the care of the Medical Service. A definite diagnosis of acute myocardial infarction was made. Because of the patient's precarious condition, all vaginal examination or therapy was forbidden by Medical Service until November 3rd when a Gyn. examination was

done with impression of CA of the cervix. A biopsy of the cervix with a diagnostic curettage was recommended, but not allowed at this time by Medical Service. A Papanicolaou smear was not done at this time as the examining room is closed on Saturday afternoon and the examination was done on the ward. The patient was sent home and readmitted to the hospital for GYN therapy 12/17/51. During her stay at home, she had marked episodes of substernal oppression and dyspnea, but no bleeding until the day prior to admission. A Papanicolaou stain and biopsy were done which showed definite CA of the cervix. Radium was inserted two days later and this was followed with deep x-ray therapy which began on 12/28/51. *Diagnosis:* Immature squamous cell carcinoma of cervix, stage 3.

Chairman: There was certainly patient delay in this case and apparently hospital delay on the part of the medical staff. The case presented many difficulties but it is hard to understand why the patient was allowed to go home for 4-5 weeks before having adequate examination or treatment. If the medical people have charge of a case you can argue but you cannot force.

Visiting surgeon: The case was discussed in staff meetings at the hospital but it was always the decision of the medical staff that the patient should not be examined.

There was discussion of the handling of this case and the problems it presented.

Cases Interviewed to February 5, 1952..... 82

Classified

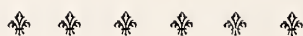
Patient Delay.....	31
No Delay.....	18
Physician Delay.....	9
Patient and Physician Delay.....	8
Institutional Delay.....	1
Patient and institutional delay.....	1
Asymptomatic Detected Cases.....	2

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70

Unclassified to date..... 12

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82



UNITY FOR A FAITH

AMOS R. KOONTZ, M.D.*

The advent of the National Educational Foundation, Inc., is heartening news to all Baltimoreans and, indeed, to all Marylanders. The medical profession has a very special reason to rejoice that, at last, an organization dedicated to "halt the planned and marked advance of socialism in our country" has been founded.

The Baltimore City Medical Society has elected to cooperate with the Foundation in its campaign to bring the truth about socialism in our Government to the people. The story of the formation of this group is best told in quoting the letter which is addressed to all prospective members and supporters. This communication reveals the reason for being, the credo and the objectives of the Foundation, and we find these aims synonymous with our own:

"The service clubs of Baltimore, to date, Civitan, Kiwanis, Lions and Rotary, are convinced that something must and can be done to halt the planned and marked advance of socialism in our country.

"The sanctity of our homes, embodied in our American 'Way of Life,' our free-enterprise system, is being eroded; it is cleverly and surreptitiously being replaced by socialism which positively leads the way to Godless communism. The campaign of destruction has been so skillfully, so insidiously planned and directed, that the majority of our people seem almost completely unaware of their plight. Many are becoming justifiably and advisedly worried and anxious as they become increasingly aware that dictatorship is being planned and practiced, and that the promised continuation of our daily freedoms is being eliminated.

"These service clubs believe that one effective way of combatting this ruinous trend is to educate and alert our citizens. Too many of our citizens in all walks of life seemingly do not realize how the uneconomic socialistic ideas originate and spread; nor are they equipped with the facts necessary to enable them to analyze and refute the fallacies of

socialistic and communistic influences and propaganda.

"Socialism was originated less than a century and a half ago by the well-fed middle class intellectuals, and did not arise from the so-called starving masses. The intellectuals, of whom it has been said, 'They know more than they understand'—are rabidly convinced that all the economic woes of mankind stem from free enterprise. It is true that free enterprise is not perfect. It has, however, given us our way of life, a scale of living, a freedom fantastically superior to any ever before known or enjoyed by the citizens of any country. Whereas Socialism, which is synonymous with Communism, has proved a decisive failure wherever practiced, it must, by reason of its own momentum, lead to Communism, dictatorship, and one goal only—man's slavery.

"Therefore, it is imperative that our citizens be alerted as to the manner and degree by which Socialism is enveloping our country. For 'Eternal vigilance is the price of liberty.'

"The Baltimore service clubs have agreed to hold joint monthly educational meetings. Acting in unison, these clubs can and will multiply their effectiveness many fold. Qualified speakers can and will be obtained; they will present truths and facts from personal experience and accurate knowledge. The subjects will cover the various phases of the development of our civilization, our economic advance versus socialism and communism both home and abroad.

"While the clubs contemplate conducting monthly luncheon meetings from January through April, 1952, it is anticipated that with the cooperation of our leading civic, social, fraternal, religious and veterans organizations, sufficient interest and enthusiasm will be aroused to justify holding monthly night meetings at the Lyric. At that time the meetings will be open to the public.

"The plan cannot be, and is not, political because it is antisocialistic and anticommunistic. Our objective is one of common interest to all true and loyal Americans who believe in home, in country, and the precious freedoms enjoyed under our present form of Government. Once the plan is functioning

* Chairman, Committee on Public Medical Education, Baltimore City Medical Society.

in Baltimore, it will be expanded over the entire State. Joint meetings of service clubs will be held in populous centers—with all citizens in the area being invited. This will, likewise, give the man at the crossroads the opportunity to hear truths and facts presented by qualified speakers.

"Simultaneously, with the introduction of the plan to the service clubs throughout the State, it will be submitted to and, it is anticipated, adopted by the national headquarters of the several clubs and thereafter organized and conducted in every State in the Union.

"The Secretary's offices of the various clubs are not equipped to handle the added tasks necessitated by this plan. Speakers must be engaged and the responsibility for their fees assumed. Literature will have to be drafted and distributed. A major effort will be required to effect the carrying out of the plan in our State and throughout the Nation.

"To carry into effect the plan, several members of the Rotary and Kiwanis Clubs have incorporated the National Educational Foundation, Inc., a Maryland nonprofit educational corporation, with offices at 1603 Munsey Building, Baltimore, Maryland. Its officers and directors are as follows:

Talbot T. Speer, President and Director (Rotary)
 John Logan Campbell, Vice-President and Director (Kiwanis)
 Harry Moores, Secretary-Treasurer and Director (Rotary)
 Dr. Waitman Zinn, Director (Kiwanis)
 Edward Cole, Director (Rotary)

"An executive committee, comprised of representatives of the service clubs, will be appointed to cooperate with their several clubs and guide and check the activities of the Foundation so that they will conform with the charter, by-laws and aims of their respective organizations.

"While the National Educational Foundation, Inc., is a nonprofit educational corporation, the Treasury Department, under its regulations, cannot at this time give it a tax-exempt status. The regulations provide that a corporation must function for some months before it can apply for and, if found eligible, receive such a rating. The reason for this is understandable. In the past, organizations with high-sounding names and objectives received an exempt

status only to prove later to be subversive in performance. However, assurances have been given that an exemption will be granted once the Treasury has examined several months of the activities.

"It is earnestly hoped that generous support will be given the Foundation by those who recognize the increasing dangers of socialism and communism. Alert, informed persons will surely know that our personal wealth today will be valueless tomorrow were socialism to engulf us."

The work which has been carried on by the Baltimore City Medical Society's Committee on Public Medical Education and of the County committees, as well, can be consolidated to advantage with the National Educational Foundation, Inc. It is clearly indicated that the organization speakers who fan out across the City, State and Nation, must, of necessity, reveal the boldest socialistic stroke of all—the President's Plan to force socialized medicine on America. The educational program *cannot* ignore the persistence of the Administration to accomplish its plan by whatever means, including the latest strategy of the "President's Commission on Health Needs of the Nation."

Joining with a sincere, determined group, such as the Foundation, is unity of the finest type. It does not mean, however, that our physicians, dentists and pharmacists can settle down and watch others fight the battle. It means, if anything, renewed vigor from them; it means backing the new forces in the field and uniting in practice, as well as theory, for our faith in the fundamentals on which our Republic was founded.

The so-called war against the socialization of the Government of the United States has been, for the most part, a weak-kneed effort, characterized by skirmishes here and there over a period of almost twenty years.

During those twenty years, the disciples of the Welfare State, of planned economy and centralized government, have cleverly campaigned and legislated, until our Government is so riddled with socialism that it is difficult to tell, at this point, where the balance lies.

The difference between the "welfare" crusaders and those who profess to love their liberty is that the crusaders have accomplished something—in fact, their mission is all but completed. They did this,

not by crusading one by one, but by uniting and taking their crusade to the people. They placed their key people in the halls of Congress; they have placed them in city and state governments; they took their story and their bribes into all strata of society, from the Ivy League to the slums. Berate them—hate them—but give them their due! They are rapidly winning what they set out to win—Government control of 160 million Americans. How do they do it? They are doing it, because they have

the energy and the fervor to see their mission through, and because they are *united*!

This is election year—a vital year for both factions in this country. This autumn will be a time of decision—for the future of the United States. Is it not high time something or someone blows the embers and rebuilds the fires under the beliefs we profess? Isn't it time we unite for a faith?

Let's be ready when we are called on to support this vital campaign against socialism!

YOU CAN'T BE A GOOD CITIZEN UNLESS YOU
VOTE

You Can't Vote Unless You
REGISTER!

DEFENSE COMMUNITY FACILITIES AND SERVICES

AMA Bulletin No. 42—82nd Congress, February 21, 1952

The President, February 14, requested supplemental appropriations for several government agencies. The request included \$25,750,000 for the Federal Security Agency to carry out the recently authorized program of federal assistance to critical defense areas for hospitals, health centers, water purification plants, sewage treatment plants, refuse disposal facilities and recreational facilities. Further, \$535,000 was requested for administrative expenses of the Federal Security Agency in connection with these responsibilities. The President also requested \$18,750,000 additional for the Housing and Home Finance Agency, which agency shares with the FSA responsibility for carrying out these programs. It will be recalled that last year Congress authorized \$60,000,000 for community facilities and services but only appropriated \$15.5 million to initiate the program. The legislation runs until June 30, 1953, and the new amounts requested would be available for expenditure until that date. The total of earlier appropriated funds plus these funds requested, equals the \$60,000,000 authorized by Congress. The first action to be taken on a request for supplemental appropriations of this type is for the Appropriations Committee to schedule hearings. We are advised that a hearing date has not yet been set but the two federal agencies involved are preparing testimony and documentation to justify the need for additional funds, using for examples several important defense areas such as Savannah River Installation, S. C.; Paducah, Kentucky (both atomic energy projects); Camp Lejeune, N. C.; Fort Hood, Killeen, Texas; San Diego, California; and Inyokern, California (military installations).

Component Medical Societies

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D., *Journal Representative*

The Anne Arundel County Medical Society held a dinner and business meeting on January 16, 1952. The following officers for 1952 were elected. *President*, George C. Basil; *Vice-President*, Irving L. Ochs; *Secretary*, Jesse L. Wilkins; *Treasurer*, J. Howard Beard; *Delegate*, Donald H. Hooker; *Alternate*, Randall McLaughlin; *Board of Censors*, Frank M. Shipley, Irving L. Ochs, Albert L. Anderson.

A renewed effort for the fight against socialized medicine was discussed. This discussion received the hearty support of all members of the Association.

A resolution was read expressing sympathy to Dr. Wilson on the death of her husband, Mr. John Wilson.

THE BALTIMORE CITY MEDICAL SOCIETY

COMMITTEES Appointed by DR. SAMUEL McLANAHAN, President January 1952

Constitution and By-Laws Committee: Moses Paulson, *Chairman*, Lawrence R. Wharton, Marius P. Johnson.

Committee on Emergency Medical Calls: Paul E. Carliner, *Chairman*, Richard M. Garrett, Clewell Howell, Louis F. Klimes, Edmond J. McDonnell, John M. Scott, David Tenner, Marion E. Wilson.

Advisory Committee to the Executive Committee of The Baltimore City Medical Society: (Appointed by Dr. McLanahan for 1952 but to be elected thereafter.) J. Edmund Bradley, Burdelle S. Cannon, Edwin B. Jarrett, Lauriston L. Keown, Samuel Whitehouse, J. Donald Woodruff.

Committee on Geriatrics: Herman Seidel, *Chairman*, Frank F. Furstenberg, Louis Krause, Thomas C. Wolff, S. Edwin Muller.

Magistrate's Committee: Roy O. Scholz, *Chairman*, Howard M. Bubert, Nathan B. Herman.

Maternal Mortality Committee: Huntington Williams, *Chairman*, D. McClland Dixon, Louis H. Douglass, Nicholson J. Eastman, Hugh B. McNally, W. Newton Long, Jr., John E. Savage, Isadore A. Siegel, W. Thurber Fales, ex-officio.

Committee to Formulate a Policy of Handling Professional Problems: William H. Smith, *Chairman*, C. Holmes Boyd, Charles N. Davidson, Max R. English, Frank J. Geraghty, J. Howard Franz, David Tenner.

Program Committee: Wetherbee Fort, *Chairman*, E. I. Cornbrooks, Jr., James C. Owings, R. Carmichael Tilghman, Henry F. Ullrich, William H. Smith, J. A. Weinberg.

Committee on Public Medical Education: Amos R. Koontz, *Chairman*, Newland E. Day, Houston S. Everett, Robert W. Garis, H. Hanford Hopkins, Douglas H. Stone. *Ex-officio Members*: Stuart M. Christhilf, Jr., Charles H. Williams, Whitmer B. Firor, George H. Yeager, Frank Black, Phar. D., Paul S. Deems, D.D.S., Stephen J. Provenza, Phar. D., Richard C. Leonard, D.D.S., Mrs. A. S. Chalfant, Mrs. H. Hanford Hopkins, Mrs. George H. Yeager, Mrs. Albert E. Goldstein, Mrs. Naomi Duff Smith, Mr. Walter N. Kirkman.

Publicity Committee: Palmer H. Fitcher, *Chairman*, John A. Nesbitt, Jr.

Advisory Committee to the Woman's Auxiliary: Marius P. Johnson, *Chairman*, Newland E. Day, Amos R. Koontz.

Legislative Committee: Daniel J. Pessagno, *Chairman*, Alan Bernstein, Howard M. Bubert, W. Graf-ton Hersperger, Edwin B. Jarrett, Erwin E. Mayer George L. McLean, Edward S. Stafford, John A. Wagner, W. Kennedy Waller.

Membership Committee: Albert E. Goldstein, *Chairman*, Damian P. Alagia, James G. Arnold, Jr., Philibert Artigiani, Nathaniel N. Beck, George H. Brouillet, Ferdinand E. Chatard, IV, Pierson M. Checket, Francis G. Dickey, Anthony F. DiPaula, Hammond J. Dugan, Jr., William L. Fearing, William L. Garlick, William E. Gilmore, George Govatos, Mary L. Hayleck, I. Bradshaw Higgins, Robert

L. Jackson, Irvin P. Klemkowski, George A. Knipp, J. H. Mason Knox, III, Fred T. Kyper, George D. Lippy, Helen I. Maginnis, Erwin E. Mayer, Karl F. Mech, Walter C. Merkel, Mitchell H. Miller, John F. Schaefer, George Sharfatz, Robert H. Siver, William G. Speed, III, Theodore E. Stacy, Jr., George A. Stewart, Douglas H. Stone, William Joseph Supik, Richard N. Tillman, W. Kennedy Waller, John B. Wells, Jr., Henry L. Wollenweber.

RADIOLOGICAL SECTION

RICHARD B. HANCHETT, M.D., *Secretary*

The Radiological Section met jointly with the Radiological Section of the Medical Society of the District of Columbia on January 17th at the Medical Society Building in Washington.

The program was presented by the staff of the Isotope Section of the National Naval Medical Center in Bethesda, Maryland and was under the direction of Commander E. R. King, M.C., U.S.N.

Two series of cases were presented of advanced malignant disease treated by radioactive gold and radioactive gallium respectively.

No conclusions were drawn but a number of interesting observations were recorded. Radioactive gold would appear to have a potential place in the armamentarium of the oncologist in the drying up of pleural or peritoneal fluid secondary to metastatic seeding. For example, a patient with lymphosarcoma, who had been "tapped" weekly prior to the introduction of radioactive gold into his pleural cavity, had but one thoracentesis subsequent to this. He has improved considerably and has been back working for several months at the time this series was discussed.

Radioactive gallium can be demonstrated to migrate to centers of osteoblastic activity in bone by the use of radioautographs. The selective concentration of this substance in such areas has suggested its possible use in bone malignancy.

SECTION ON DISEASES OF THE CHEST

EDMUND G. BEACHAM, M.D., *Secretary*

1. The tenth meeting of the Section on Diseases of the Chest was held January 2, 1952. Dr. M. S. Shiling, Chairman, presided with 30 physicians and visitors present.

2. Treasurer reported \$115.58 on hand due pri-

marily to \$100 received as contributions from members following annual letter to those on our mailing list.

3. It was decided to have 3 meetings yearly in addition to participation in the annual meeting. Months chosen were November, January, and March.

4. The scientific portion of the meeting consisted of a discussion of "Tuberculosis in the Negro" by Dr. Howard M. Payne, Professor in Medicine, Howard University, College of Medicine.

Dr. Payne commented on recent statistics of tuberculosis showing a marked increase in incidence in those over 55. In addition prevalence of disease seemed about the same in racial groups although fatality was increased in certain segments as Negroes and Indians.

He felt that antibiotics played a great role in treatment of tuberculosis, but other factors such as "resistance" were of basic importance. History of the individual patient and his family often were of prognostic importance.

Dr. Payne reported a startling "epidemic" of tuberculosis in a group of young seminarians under great strain including fasting. He said that nutrition particularly protein metabolism is an important consideration in any discussion concerning tuberculosis. Progressive tuberculosis is rare in groups enjoying a high standard of living.

He posed the question "whether bed rest is being overdone?" and urged earlier graduated exercise in chosen cases.

Dr. Payne commented briefly on the positive value of home treatment with antibiotics to prepare patients for early surgery. He urged close cooperation of physicians with social and rehabilitation workers and agencies.

ANESTHESIOLOGY SECTION

EDWARD I. LEDERMAN, M.D., *Secretary*

The January meeting of the Anesthesiology Section was held at 1211 Cathedral Street. The speaker was Brigadier General Sam Seeley, Chief of Surgical Section, Walter Reed General Hospital.

The General spoke on "Shock." Highlights of the talk were:

1. A new type flask for blood. The flask is made of plastic and will resist breakage. It can be packed and stored easily. It can be emptied rapidly by

pressure of the hands without danger of introducing large quantities of air into the vein or artery of the patient.

2. Intra-arterial transfusion was discussed and its use in cardiac conditions producing shock were brought out. Its use in "surgical shock" was again emphasized.

3. The importance of preoperatively correcting blood volume or concentration was emphasized. This is a major factor in reducing "surgical shock" during operative procedures.

OPHTHALMOLOGICAL SECTION

ANGUS L. MACLEAN, M.D., *Secretary*

The first meeting of the Ophthalmological Section was held on Thursday, November 29th. The President of the Section, Dr. Abraham Kremen, presided. After a few introductory remarks and announcement of the coming meetings, the guest speaker, Dr. Ralph Lloyd of Brooklyn, New York, was introduced.

The title of Dr. Lloyd's paper was "Ophthalmoscopic Diagnosis in Unusual Fundus Cases." In his preliminary remarks, Dr. Lloyd stressed the importance of, (1) careful follow-up, sometimes for a matter of years, on all interesting and unusual fundus cases and, (2) the importance of eventually checking or comparing, wherever possible, the ophthalmoscopic diagnosis with pathological findings. A number of fundus pictures of the following conditions were shown: (1) extra-papillary coloboma, (2) disciform Junius-Kuhnt or retinal degeneration, (3) angioid streaks, (4) retinitis punctata albescens, (5) chorioideremia. The fundus pictures for each group were followed by microphotographs to show and demonstrate pathological findings for each group.

A new term, "pseudotumor of the retina," was introduced, to cover that group of degenerative retinal lesions in the posterior pole, characterized by the formation of a large organized connective tissue mass and in the past described under different headings, and more recently as, disciform retinal degeneration or Junius-Kuhnt retinal degeneration.

By means of a careful pathological examination of one or two cases, Dr. Lloyd was able to show that the pathological process of angioid streaks was similar to that of pseudotumor of the macula; that they probably occur as a result of extravasations from the choriocapillaris by way of Bruch's membrane into the subretinal space.

The paper was discussed by Drs. Alan C. Woods and Clyde A. Clapp. Dr. Woods thought that the new term "pseudotumor of the retina" was an extremely good one and both he and Dr. Clapp expressed interest in Dr. Lloyd's new ideas concerning the origin and pathogenesis of angioid streaks. Dr. Clapp thought that Dr. Lloyd had been more fortunate than most of us in being able to secure specimens with these unusual fundus lesions, for pathological study.

SURGICAL SECTION

E. RODERICK SHIPLEY, M.D., *Secretary*

An unusually interesting program was presented by the Staff of the U. S. Public Health Service Hospital, where the meeting was held. Approximately 41 surgeons attended the meeting. The following papers were presented and were followed by a general discussion.

1. "An unusual case of arterial sclerosis obliterans" by Dr. James L. Southworth, Deputy Chief of Surgery
2. "The use of discograms in the diagnosis of herniated nucleus pulposus" by Dr. John J. Davies, Chief Orthopedist—Presented by Dr. William Crawford, Surgical Resident
3. "Bacterioides infection of abdomen, a presentation of two cases" by Dr. Norman Tarr, Surgical Resident
4. "Resection of upper thoracic esophagus for benign disease in adult" by Dr. M. L. Brockmeyer, Assistant Chief of Tumor Service
5. "Surgical treatment of megacolon, case report" by Dr. H. D. Fishburn, Chief Surgeon

Meetings

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

BALTIMORE CITY MEDICAL SOCIETY
1211 Cathedral Street, Baltimore, Maryland

SAMUEL McLANAHAN, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*
J. ALBERT CHATARD, M.D., *Treasurer*

SEMIANNUAL MEETING

Friday, April 18, 1952, 8:30 p.m.

1. Civil Defense. Brigadier General R. P. Williams, Chief Medical Services, Civil Defense, Maryland State Department of Health.
2. Movies of the Physical and Pathological Effect of Atomic Warfare.
3. Demonstration by the Red Cross of the New Method of Artificial Respiration.

BUFFET SUPPER

ANESTHESIOLOGY SECTION

OTTO C. PHILLIPS, M.D., *Chairman* EDWARD I. LEDERMAN, M.D., *Secretary*

Tuesday, April 1, 1952, 8:30 p.m.

1. Business Session.
 2. Case reports of the Anesthesia Study Commission.
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**WOMAN'S AUXILIARY
TO THE
BALTIMORE CITY MEDICAL SOCIETY**

MRS. H. HANFORD HOPKINS, *President* MRS. MARIUS P. JOHNSON, *Secretary*
MRS. HARRY C. BOWIE, *Treasurer*

Wednesday, April 2, 1952, 11:00 a.m.

Mrs. Harold F. Wahlquist, President of the Woman's Auxiliary to the American Medical Association, and member of the Board of the American Medical Association, will be the guest speaker.

COLLATION

NEUROPSYCHIATRIC SECTION

SAMUEL NOVEY, M.D., *Chairman*

Thursday, April 10, 1952, 8:30 p.m.

Group Psychotherapy. *Speaker to be announced.*
Discussion opened by Jerome D. Frank, M.D.

Component Medical Societies

ORTHOPAEDIC SECTION

JESSE N. BORDEN, M.D., *Chairman* EDMOND J. McDONNELL, M.D., *Secretary*

The Orthopaedic Section of the Baltimore City Medical Society will be the guests of the Orthopaedic Section of Washington, D. C., in April.

RADIOLOGICAL SECTION

J. HOWARD FRANZ, M.D., *Chairman* RICHARD B. HANCHETT, M.D., *Secretary*

Tuesday, April 15, 1952

Dinner 6:00 p.m., Sheraton Belvedere Hotel

Scientific Session, 8:30 p.m., 1211 Cathedral Street

Radioactive Isotopes in Medicine. Kenneth E. Corrigan, Ph.D., Director, Radiological Research Department, Harper Hospital, Detroit, Michigan. (By invitation.)

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, April 17, 1952

5:00 to 6:00 p.m.

PATHOLOGY SECTION

WILLIAM V. LOVITT, JR., M.D., *Secretary*

Monday, April 21, 1952, 7:30 p.m.

U. S. Public Health Service Hospital

Program to be announced.

MATERNAL MORTALITY MEETING

Thursday, April 24, 1952, 4:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department

BALTIMORE COUNTY MEDICAL ASSOCIATION

THOMAS E. WHEELER, M.D.,

Journal Representative

The regular meeting of the Baltimore County Medical Association was held on Wednesday, January 23 at the Penn Hotel in Towson. New officers installed were *President*, Charles H. Williams; *Vice-President*, Charles F. O'Donnell; *Secretary-Treasurer*, Thomas E. Wheeler; *Delegates*, David H. Andrew, James G. Howell, Melvin B. Davis; *Alternates*,

Martin Strobel, Harry G. Butler, Wilmer K. Gallagher.

Dr. Melvin B. Davis, the retiring President, presented an annual report of the activities to the Association. Dr. Davis enlarged upon the relationship of socialized medicine to socialism in government. He went on to explain the majority of meetings during the past year had been devoted to Health Department-physician relationship throughout the State as it affects the general practitioner. He felt that this intensive exploration was important and urged the new officers of the Association to carry on this important project during the coming year.

The retiring President closed his report with an expression of appreciation to Dr. William H. F. Warthen, Health Officer of Baltimore County, for his cooperation and help in aiding him in investigating the Health Department-physician relationship during the past year.

Consideration was given at the meeting to a revision of the Constitution and By-Laws of the Association and to reports of standing committees.

The March meeting will be held on the 19th of the month and the location will be Rosewood State Training School. The program will consist of luncheon, business meeting and the scientific section. The topic of discussion will be Clinical Aspects of Certain Types of Mental Deficiency. Participants will be Dr. George L. Wadsworth, Superintendent, Dr. George C. Medairy and Dr. Harry G. Butler of the Rosewood State Training School.

CECIL COUNTY MEDICAL SOCIETY

RICHARD C. DODSON, M.D.,

Journal Representative

At the regular meeting of the Cecil County Medical Society held on January 23, 1952, the following officers were elected for 1952. *President*, Seymour Goldgraben; *Vice-President*, S. Ralph Andrews; *Secretary-Treasurer*, Richard C. Dodson; *Delegate*, H. A. Cantwell; *Alternate*, Richard C. Dodson.

Dr. H. Wollenweber, pathologist of Union Hospital and Dr. Georgianna Seegar-Jones endocrinologist of The Johns Hopkins Hospital discussed a paper on functional bleeding and treatment.

The Woman's Auxiliary to the Cecil County Medical Society decided at their meeting to become Members at Large to the State Society, rather than continue as an organization at this time.

THE CHARLES COUNTY MEDICAL SOCIETY

J. PARRAN JARBOE, M.D.,

Journal Representative

The Charles County Medical Society met on January 10, 1952. At this meeting the following officers for 1952 were elected. *President*, Arthur O. Wooddy; *Vice-President*, James E. Andrews; *Secretary-Treasurer*, J. Parran Jarboe; *Delegate*, John H. Griffin; *Alternate*, William A. Harris; *Chief of Staff of Physicians Memorial Hospital*, W. C. Espach.

Meetings are held regularly on the second Thursday of each month from September to June at 8:30 P.M. in the Jarwood Clinic, La Plata. Members of the state society are invited to attend and will be welcomed at any meeting. Refreshments are served. The meetings are held to discuss business matters, scientific papers and events.

HOWARD COUNTY MEDICAL SOCIETY

THEODORE R. SHROP, M.D.,

Journal Representative

Since the society has only bimonthly meetings it was felt that not enough attention was being given to professional advancement. To correct this situation an interval Bimonthly Seminar has been instituted. These meetings are held on the last Friday of the even numbered months.

These meetings are addressed by selected specialists from Baltimore. They start promptly at 2:30 P.M. and close at 4:30. The papers and the discussions are tape recorded, transcribed, mimeographed, bound in a folder and copies are given to the members and the speakers.

Considerable interest has been exhibited and curiously it appears that the speakers are most interested. The meetings are held for the present at the County Health Department office. Visitors are welcome. Further details can be secured by contacting the President or Secretary.

KENT COUNTY MEDICAL SOCIETY

ROBERT E. ENSOR, M.D.,

Journal Representative

At a recent meeting of the Kent County Medical Society the following officers were elected for the year 1952. *President*, H. H. Hamilton; *Vice-President*, A. F. Whitsitt; *Secretary-Treasurer*, A. C. Dick; *Delegate*, Robert W. Farr; *Alternates*, Robert E. Ensor, Oskar S. Gulbrandsen.

Dr. Willard F. Smith opened his office for general practice of medicine on January 12, 1952, at Rock Hall, Maryland. Dr. Smith is a native of Wilmington, Delaware. He was graduated from Temple Medical School in 1950 and interned at Delaware Hospital in Wilmington.

The regular quarterly joint meeting of Kent, Queen Anne, Caroline, and Talbot County Medical

Societies was held at Denton, Maryland on January 17th. Dr. Frank Kaltreider led a discussion of obstetrical cases that had been before the Maternal Mortality Committee.

ST. MARY'S COUNTY MEDICAL SOCIETY

J. ROY GUYTHER, M.D.,

Journal Representative

At the annual meeting of the St. Mary's County Medical Society, the following officers were elected: *President*, W. H. Patrick; *Vice-President*, Robert T. Fuchs; *Secretary-Treasurer*, J. Roy Guyther; *Delegate*, Alan D. Houser; *Alternate*, Frank A. Camalier.

WASHINGTON COUNTY MEDICAL SOCIETY

W. D. CAMPBELL, M.D.,

Journal Representative

The Washington County Medical Society held its first meeting of 1952, on January 24 at the Hotel Alexander in Hagerstown. Dr. Ernest F. Poole and Dr. Perry F. Prather were commended for their direction of the medical phase of the local Civilian Defense program.

Dr. Victor D. Miller has been a member of the Washington County Medical Society for 50 years. Dr. Miller was born in Washington County, Maryland and was graduated from the University of Pennsylvania Medical School in 1900, where he was a member of the Phi Kappa Sigma Fraternity. Following graduation he served as resident physician at Germantown Hospital, Philadelphia, Pennsylvania and Kings County Hospital in Brooklyn, New York. He began the practice of medicine in Hagerstown, Maryland in 1901, and became a member of the Medical Staff of the Washington County Hospital in 1905. He was instructor of communicable diseases in the Nurses Training School there until 1946. He has been very active in Civic affairs, being past president of the Chamber of Commerce, Rotary Club, and Washington County Chapter of Red Cross. In addition, he was a member of first Board of Governors of Y. M. C. A., Washington County Public Health Association, and Community Chest, and on the Board of Street Commissioners of Hagerstown for six years. During World War I and World

War II he was on the Medical Advisory Committee to the local draft board. Dr. Miller is still active in the Medical and Civic life of Washington County.

Drs. Richard T. Binford and J. Dean Wilson were unanimously elected to membership in the Society. Dr. Binford is engaged in the practice of Internal Medicine in Hagerstown, and Dr. Wilson in general practice in Smithsburg. The new officers were installed and committees announced.

The meeting was concluded by R. E. Warren Smith, an instructor trainer of the Washington County Chapter of the American Red Cross who demonstrated the Hoyer-Nielsen method of resuscitation, which has now been accepted as official by our Military and Civilian Defense Forces. This method has as its principle advantage over older methods, an increase in the efficiency of the inspiratory phase, which is achieved by muscle pull by the operator rather than spontaneously.

WORCESTER COUNTY MEDICAL SOCIETY

HERMAN A. ROBBINS, M.D.,

Journal Representative

At a recent meeting of the Worcester County Medical Society, the following officers were elected. *President*, Clifford E. Schott; *Vice-President*, Norman E. Sartorius, Sr.; *Secretary-Treasurer*, Herman A. Robbins; *Delegate*, Francis J. Townsend, Jr.; *Alternate*, Norman E. Sartorius, Jr.

The Worcester County Medical Society is sponsoring a contest for high school students on the A. A. P. S. subject, "Why the United States Offers the Best Medical Service in the World." Cash prizes for the best essays written in this county will be \$30.00, first prize; \$20.00, second prize; \$10.00, third prize. The best three papers will be sent to the National Headquarters for further consideration. The prizes were made up from individual donations to stimulate interest in the National Essay Contest.

PEDIATRIC SEMINAR

A seminar on pediatrics will be held at the University of Maryland School of Medicine on Sunday, May 11, 1952.

The program is designed for general practitioners. All practising physicians are invited to attend this meeting.

PROGRAM

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| <p>10:00-10:05 a.m. Welcome. J. Bradley, M.D.
Moderator. Frederick B. Smith, M.D., Associate Professor of Pediatrics, University of Maryland School of Medicine.</p> <p>10:05-11:00 a.m. Certain Pediatric Aspects of Infant Feeding. Preston A. McLendon, M.D., Professor of Pediatrics, Georgetown University School of Medicine.</p> <p>11:00-11:30 a.m. Discussion.</p> <p>11:30 a.m.-12:30 p.m. Common Pediatric Surgical Conditions. C. Everett Koop, M.D., Surgeon-in-Chief, The Children's Hospital of Philadelphia.</p> <p>12:30- 1:00 p.m. Discussion.</p> | <p>1:00- 2:30 p.m. A light lunch will be served in the Gordon Wilson Hall.</p> <p>2:30 p.m. Moderator. Harry H. Gordon, M.D., Director of Pediatrics, Sinai Hospital; Associate Professor of Pediatrics, The Johns Hopkins Hospital.</p> <p>2:30- 3:30 p.m. Behavior Problems Associated with Feeding. Harry Bakwin, M.D., Professor of Clinical Pediatrics, New York University—Bellevue Medical Center.</p> <p>3:30- 4:00 p.m. Discussion.</p> <p>4:00- 5:00 p.m. Office Management of the Allergic Infant and Child. Jerome Glaser, M.D., Assistant Professor of Pediatrics, University of Rochester.</p> <p>5:00- 5:30 p.m. Discussion.</p> |
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Nobody's too busy to REGISTER

Nobody's too busy to VOTE!

DON'T NEGLECT YOUR PRACTICE IN CITIZENSHIP!

VA REPORTS IT HAS 475 VACANCIES FOR PHYSICIANS

AMA Capitol Clinic Vol. 3, No. 9, March 4, 1952

The Veterans Administration has informed Congress that 475 medical posts, for which funds have been appropriated, remain unfilled because of inability to procure physicians. Dr. C. F. Bayer, Chairman of a special board, listed these VA vacancies in testimony before Senate Committee on Expenditures in the Executive Departments as: Neuro-psychiatrists, 140; general medicine, 113; surgery and sub-specialties, 106; tuberculosis, 54; radiologists, 18; pathologists, 24; administration, 11; and physical medicine, 9. Dr. Bayer said there was a shortage of 300 nurses for general medicine; 192 for tuberculosis and 186 for NP hospitals. He described the situation as "abnormal."

Library

HOW THE LIBRARY CAN SERVE THE PHYSICIAN

PAULINE DUFFIELD, *Librarian*

Many of our members may not know that the library can save time and effort for them. Faculty members, who have interesting case reports to compile or speeches and articles to be written, should take advantage of the opportunities presented by the library.

Services offered by the library have been developed with the enthusiastic approval of the library committee, the doctors and the library staff. This includes the preparation of bibliographies on any subject, verifying references or securing any needed material. All work done by the library staff is without charge. Requests for reference work may be made by telephone, letter or by a personal visit.

The physician, located outside of Baltimore, need not hesitate to ask for material. In making a request, it is always helpful to supply as much information as possible so that the library staff can do a more intelligent piece of work and the material can be sent without delay.

For a complete coverage of a request it would be of the greatest assistance to the library staff, if the purpose of the material is stated and if information is given to such questions as: is the material to be used in preparation of an article; is current material all that is needed; how many years should be covered; shall historical material be included; should the material be limited to the English language; should material not available in our library be listed; and how soon is the material needed.

For those not knowing of the value that might be received by use of the library, may we suggest some medical reference tools that will aid in the search for answers to the various problems confronting the individual.

The most useful literary research tool is the INDEX MEDICUS. This A. M. A. publication is

arranged by author and subject in alphabetical order. 1950 is the latest volume.

There are several sources to use in locating current material. One source is the CURRENT LIST OF MEDICAL LITERATURE, which is published by the Army Medical Library. This list indexes all medical journals that are received by the Army Medical Library. The index, with the journals arranged in alphabetical order, is used to find the desired material. Another source is the index issue of each volume of the J. A. M. A. This issue indexes and also abstracts original material.

The EXCERPTA MEDICA, in fifteen specialty editions, is a monthly publication that abstracts the world's best medical publications. It abstracts about two thousand of the world's seven thousand journals. The publication is in English and is a relatively new venture in the field of medical abstracting, having been started in Holland by Dr. M. W. Woerdeman in 1949.

The year books in various specialty fields are also helpful in reviewing literature of the preceding year.

For older material, the INDEX CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE is the most complete. It lists all books and journals, which were received by the Army Medical Library before 1948. It is arranged according to authors and subjects in alphabetical order. Unfortunately, this publication was suspended with the third series (Volume X) in 1948.

The Faculty library has complete files of most of the American and English journals as well as many foreign ones. At the present time, we are receiving 346 current journals.

When needed material is not available in the city, we are privileged to borrow from many out-of-state medical libraries. If the material can not be borrowed, it is possible to obtain a photoprint or microfilm.

The purpose of the library is to make information available. The services rendered should be considered as "good public relations."

DISPOSITION OF BOOK COLLECTIONS

Many members have asked about various collections of books and journals received each year by the Faculty library. Each collection is checked against the library content. If the material is needed, or is of historical value, it is added to our library. If the material is found to be duplicated, it is offered to the Medical Library Association Exchange, which lists duplicate material from medical libraries all over the world. In this way, material is sent to libraries where it is most needed. Over many years, we have been fortunate in completing several of our broken sets by the many gifts received from our members and the Medical Library Association Exchange.

There are two schools of thought on the disposition of private book collections: 1) to dispose of them by sale or, 2) to give the collection to a library. We are proud of the many fine collections of books given by members of the Faculty, and hope that in the future, as in the past, collections made by the members will come to the library. It is pleasing that so many have sent us their current journals as soon as they have read them. All gifts, large or small, are a welcome addition to the library.

The latest collection to be presented to the library has come from the library of the late Dr. Harvey G. Beck. We wish to express our appreciation to Mrs. Beck for this collection of 1,309 items.

CURRENT ARTICLES BY FACULTY MEMBERS

- BEACHAM, EDMUND G. & MACHT, STANLEY H., Chest surveys of the aged. *Dis. Chest*, **21**: 102-107, Jan., 1952
- BERESTON, EUGENE S., Contact dermatitis due to N-Ethyl-O-Crotonotoluide Ointment (EURAX). *Arch. Dermat. & Syph.*, **65**: 100-101, Jan., 1952
- BRANTIGAN, O. C., Thoracoplasty in the treatment of pulmonary tuberculosis. *Am. Surgeon*, **18**: 6-29, Jan., 1952
- DELANEY, ADRIAN J. & MORSE, HARRY R., Inferior meatal accessory ostia. *Ann. Otol., Rhin. & Laryng.*, **60**: 635-637, Sept., 1951
- DIEHL, WILLIAM K., BAGGETT, JOSEPH W. & SHELL, JAMES H., Vulval cancer. *Am. J. Obst. & Gynec.*, **62**: 1209-1218, Dec., 1951

- FINBERG, LAURENCE, Factors affecting prognosis of tuberculous meningitis treated with streptomycin. *Pediatrics*, **8**: 768-771, Dec., 1951
- GREEN, ROBERT E. & DOUGLASS, CARLETON C., Intracranial division of the eighth nerve for Meniere's Disease. *Ann. Otol., Rhin. & Laryng.*, **60**: 610-621, Sept., 1951
- HINGSON, ROBERT A. & HELLMAN, LOUIS M., Organization of obstetric anesthesia on a twenty-four hour basis in a large and a small hospital. *Anesthesiology*, **12**: 745-752, Nov., 1951
- JEWETT, HUGH J., Infiltrating carcinoma of the bladder. *J. A. M. A.*, **148**: 187-189, Jan. 19, 1952
- JOHNSON, HERBERT C. & WALKER, A. EARL, The angiographic diagnosis of spontaneous thrombosis of the internal and common carotid arteries. *J. Neurosurg.*, **8**: 631-659, Nov., 1951
- KAISER, IRWIN H. & CUSHNER, IRVIN M., The efficiency of placental exchange in the human subject at the time of delivery as determined by radiosodium tracer techniques. *Am. J. Obst. & Gynec.*, **62**: 1300-1306, Dec., 1951
- KOONTZ, AMOS R., The operation for difficult sliding hernia of the large bowel. *Am. Surgeon*, **18**: 78-84, Jan., 1952
- LANG, FREDERICK R., A study of the use of radioactive gallium in medicine. *Ann. Int. Med.*, **35**: 1237-1249, Dec., 1951
- LEWISON, EDWARD F. & CHAMBERS, ROBERT G., The sex hormones in advanced breast cancer. *New England J. Med.*, **246**: 1-8, Jan. 3, 1952
- H. J. L. M. [MARRIOTT, HENRY J. L.] Editorial, Recent studies on the treatment of motion sickness. *Ann. Int. Med.*, **35**: 1383-1389, Dec., 1951
- MEISEL, HERMAN J. & MILLER, JOSEPH M., Giant hydronephrosis on the left side of a horseshoe kidney. *Urol. & Cutan. Rev.*, **55**: 739-741, Dec., 1951
- MILLER, JOSEPH M. & LIPIN, RAYMOND J., Gastroileostomy. *Rev. Gastroenterol.*, **18**: 854-858, Dec., 1951
- OLSON, BYRON J. & OTHERS, Experimental tuberculosis. *Am. Rev. Tuberc.*, **65**: 48-63, Jan., 1952
- RICHTER, CURT P., The physiology and cytology of pulmonary edema and pleural effusion produced in rats by Alpha-Naphthyl Thiourea (ANTU). *J. Thoracic Surg.*, **23**: 66-91, Jan., 1952
- ROACH, JOHN F., SLOAN, ROBERT D. & MORGAN,

- RUSSELL H., The detection of gastric carcinoma by photofluorographic methods. *Am. J. Roentgenol.*, **67**: 68-75, Jan., 1952
- ROBINSON, RAYMOND C. V., Contact dermatitis from silicone putty. *Arch. Dermat. & Syph.*, **65**: 99-100, Jan., 1952
- WAGNER, JOHN A., Trauma and primary brain tumor. *M. Ann. District of Columbia*, **20**: 650-652, Dec., 1951
- WOODS, ALAN C., Cortisone in interstitial keratitis. *Am. J. Syph.*, **35**: 517-524, Nov., 1951

HANDBOOK ADVISES ON CONTROL OF RADIOACTIVE CONTAMINATION

AMA Control Clinic Vol. 3, No. 9, March 4, 1952

A new Bureau of Standards handbook (15 cents at Government Printing Office, Washington 25, D. C.) gives detailed information on laboratory procedures "designed to minimize the possibility of accidents involving radioactivity and to minimize the effects if such accidents do occur." The Bureau recommends it as a guide for universities and hospitals.

AMERICAN MEDICAL EDUCATION FOUNDATION

AMA Secretary's Letter No. 209, February 18, 1952

Dr. John W. Cline, President, announced that the A.M.A. Board of Trustees had approved in principle a plan whereby the A.M.A., as a corporation, would accept patients for medical discoveries made by member physicians. All royalties, he said, would be turned over to the American Medical Education Foundation for distribution to medical schools.

Board of Medical Examiners

A DISCUSSION OF SOME OF THE PROBLEMS ASSOCIATED WITH LICENSURE

LEWIS P. GUNDRY, M.D., *Secretary*

In the State of Maryland physicians are licensed in one of three ways:—by successfully completing a written examination; by reciprocity with the license issued by another state or the District of Columbia; or by endorsement of the certificate of the National Board of Medical Examiners. Written examinations are given by the Board twice each year—in June and December.

To be eligible for examination a candidate must be a graduate of a medical college with standards meeting the requirements of the Association of American Medical Colleges.* When taking examinations each candidate is assigned a number so that his name does not appear anywhere on his paper. In this way fairness and impartiality are assured.

Graduates of foreign medical schools who apply for permission to take the examination present certain problems. Many of these schools suffered great losses both in their teaching personnel and in their physical equipment as a result of the first and

* Canadian Medical Schools are considered as approved schools in the United States.

second world wars. The present policy is to accept graduates of those foreign schools which have been found to approximate the standards of recognized medical schools in this country.

During the five year period from 1946 to 1951, 963 physicians took the written examinations. Out of 873 graduates of United States and Canadian Medical Schools there were 10 failures. Out of 90 graduates of foreign medical schools there were 35 failures or 39%. This is similar to the experience of other states.

The executive committee of the Board, which consists of the president, vice-president, and secretary, meets as the occasion demands to consider applicants for licensure by reciprocity from another state or by endorsement of the National Board certificate. Each applicant presents his credentials and is given a brief interview.

During the last five years 457 physicians have been licensed from other states and 245 by endorsement of the National Board certificate. Thus a total of 1620 physicians have been licensed over a five year period in Maryland.

REVOCATION OF MEDICAL LICENSES

“The Council of the Medical and Chirurgical Faculty is in full support of the Board of Medical Examiners in their action in taking the licenses away from physicians convicted in Court of income tax evasion, and further desires that this support by the Council be publicized in the Maryland State Medical Journal.”

Excerpt from Council minutes, November 1951 and February 1952.

Insurance

BLUE CROSS AND BLUE SHIELD

The Sheraton Belvedere Hotel was the scene of the Annual Blue Cross Corporation dinner on Wednesday, January 30, 1952. At this meeting Mr. Reginald H. Dabney, Blue Cross Director, made the annual report to the assembled Directors of Blue Cross and Administrators of various hospitals throughout Maryland as well as other friends of Blue Cross. Sixty guests were present.

In his report, Mr. Dabney gave a few interesting figures as to the progress of Blue Cross in the last year. There were 100,304 Blue Cross subscribers needing hospital care in 1951; an increase of 9,753 over 1950. Blue Cross paid \$7,544,775 to the various hospitals in Maryland. This figure is an increase of over one million dollars from the 1950 figure.

Over 842,000 members now belong to the Blue Cross plan in Maryland. This means an average of more than one out of every three persons in Maryland belong to Blue Cross.

Figures were released on the first year of Blue Shield's operation in Maryland by Dr. Hugh J. Jewett, President of the Board of Trustees of the Maryland Medical Service. Dr. Jewett pointed out that during the first year over 159,000 Blue Cross subscribers took advantage of the opportunity to join Blue Shield.

The Bethlehem Steel plan of approximately 50,000 members stands as Blue Shield's largest single group. Dr. Jewett's report revealed that 6,962 Blue Shield subscribers received benefits during the past year. A total of \$416,000 was paid, which covered more than 74% of the total cost of the care for these patients.

Mr. Dabney, Executive Director of Blue Cross and Blue Shield, was quoted as saying:

"Joining forces to provide service to these hundreds of thousands of subscribers are 9,100 employers, 39 member hospitals and 1,530 physicians. They have united the community to enable it to budget through Blue Cross and Blue Shield and to provide protection against those illnesses which otherwise would wreck so many family budgets.

"The program's greatest value to the subscriber lies in its unique service benefits—an invaluable protection against the rising cost of hospital care." Mr. Dabney went on to state "that over 41,000,000 Blue Cross subscribers in America and more than 21,000,000 Blue Shield subscribers attest to the widespread acceptance of this prepayment health care program."

Just recently, arrangements have been completed to offer Blue Cross to the student body at The Johns Hopkins University. With the cooperation of the University Physician, Dr. Frank R. Smith, Jr., and other Administrative officials at Hopkins, Blue Cross will be presented to the students in the Fall of 1952.

Aside from the medical students at The Johns Hopkins University School of Medicine, to whom Blue Cross is compulsory, this type of program has not been attempted previously. A letter will be sent before the beginning of the Fall term to the students at Hopkins, Homewood Campus. In September, Blue Cross will have a booth near the registration desks. It is hoped that through these efforts, the quota will be reached. If this move is successful, Blue Cross may be offered in the future to other University students throughout Maryland.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

COMING IN APRIL!

Three important events to which all members of The Woman's Auxiliary To The Medical and Chirurgical Faculty and all wives of Faculty members are cordially invited!

I. To meet MRS. HAROLD F. WAHLQUIST, National President, The Woman's Auxiliary To The American Medical Association, who will address a State-Wide Auxiliary meeting at 11 o'clock A.M., on Wednesday, April 2nd at 1211 Cathedral Street, Baltimore. A buffet luncheon will follow the meeting. Members of the State Auxiliary will be guests of The Woman's Auxiliary to the Baltimore City Medical Society.

THE WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY wishes to express its gratitude to the WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY for persuading Mrs. Wahlquist to speak at their regular April meeting and for their hospitable invitation to the State Auxiliary on this occasion. Otherwise our Maryland Auxiliary would have lost the opportunity to hear the National President, whose plans to attend our Annual State Meeting were frustrated when the Faculty changed its original meeting date.

THIRD ANNUAL MEETING

II. THE WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND will hold its Annual Meeting on Wednesday, April 30th at the STAF-FORD HOTEL, Charles and Madison Streets, Baltimore, Maryland. "Our work is done—so let's have fun."

TENTATIVE PROGRAM ANNUAL MEETING

MRS. THOMAS A. CHRISTENSEN, *Chairman of Arrangements*

MRS. GEORGE H. YEAGER, *President*, Presiding

MRS. PAGE C. JETT, *Treasurer*

MRS. H. VINCENT DAVIS, *Recording Secretary*

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

Registration From 11:00 A.M.

10:00 a.m.—11:00 Preconvention Board Meeting
(It is imperative that all officers and chairmen of the Woman's Auxiliary to the Medical and Chirurgical Faculty attend this meeting.)

11:00 a.m.—12:00 A showing of exhibits available for Auxiliary "Health Booths" at County Fairs this summer followed by a Round Table on Auxiliary work moderated by State Auxiliary Chairmen and Officers. Movies to be shown—"Frontiers In Medical Research" obtained from The Maryland Society for Medical Research, and "Girls In White" obtained through the A. M. A.

Exhibits to be seen include one on Medical Research, an electrical question and answer box modeled on one originated by the Massachusetts' Woman's Auxiliary. This is made by and is available from the Maryland Society for Medical Research. Another exhibit will be on "Quackery" from the A. M. A.

12:00 m.—1:00 Business Meeting.

1:00 p.m.—2:45 Luncheon; Lecture; Fashion Show.
Speaker, Dr. Louis Krause on "Medicine and the Bible"

(Your husband is invited to have lunch with us as Dr. Krause's talk will be of interest to all)

2:45 p.m.— 3:00 Election of Officers
 3:00 p.m. Adjournment of General Session
 3:00 p.m.— 3:30 Post Convention Board Meeting

Officers and Chairmen of State Auxiliary will serve as the Hospitality Committee, under the Chairmanship of Mrs. George G. Finney.

Names of the Committee on Arrangements and of the Creative Arts Show Committee will appear in the April issue of this journal.

III. THE CREATIVE ARTS SHOW will be held during the annual meeting of the Medical and Chirurgical Faculty from Monday, April 28th through Wednesday, April 30, 1952. Mrs. Beverley C. Compton is Chairman. Paintings, ceramics, furniture, weaving, photography, etc., by doctors, their wives and children will be shown (entries must be delivered to the Faculty building, 1211 Cathedral Street, Baltimore 1, Maryland on Wednesday and Thursday, April 23rd and 24th).

Write or telephone Mrs. Beverley C. Compton, Lake Station, Ruxton 4, Maryland (Telephone—Towson 7090) if you wish to enter the show. Two exhibits per person will be accepted, space permitting. "Don't miss this 2nd Annual Talent Show."

NEWS FROM THE COMPONENT AUXILIARIES

Members tell us that the Baltimore County Auxiliary is getting well organized for a good year's work under its newly elected officers.

The Baltimore City Auxiliary has distributed A. M. A. educational literature to the Farm Bureau due to the successful work of Mrs. John Askin and Mrs. Charles Levy.

We regret that Cecil County feels that its handful of members are too few to function as a unit. They have been very valuable to us and we shall still count on them as members at large.

REQUESTED REVISIONS TO THE CONSTITUTION

The Medical and Chirurgical Faculty has requested that the constitution of the Woman's Auxiliary be changed so that the last sentence will read—"that this Auxiliary may endorse or oppose pending legislation and assume a stand on matters of public policy with the approval of the Council of the Medical and Chirurgical Faculty."

RESOLUTIONS for consideration at the annual

meeting must be sent to Mrs. Amos L. Koontz, chairman, Garrison, Maryland by April 1st.

SOMETHING TO THINK ABOUT

Some members have suggested that instead of a Medical Scholarship the State Auxiliary ought to give a sum of money each year to the A. M. A. educational fund for medical education. The Colorado Woman's Auxiliary has contributed to this fund. The Woman's Auxiliary to A. M. A. gave \$10,000 to the National Educational Fund in 1951.

"DOCTOR'S DAY 1952"

MRS. E. PAUL KNOTTS, *Doctor's Day Chairman*

"Doctor's Day", a tribute to the medical profession is celebrated on March 30th in commemoration of the first use of anesthesia by Dr. Crawford Long on March 30, 1842 at Jefferson, Georgia. Conflicting claims as to the first use of anesthesia do not concern us since it is not primarily our purpose to honor any specific physician.

Several Component Auxiliaries celebrated Doctor's Day in excellent and original ways last year. The Baltimore County Auxiliary, for example, held a Doctor's Day dance at which money was raised for Maryland's first Auxiliary sponsored nursing scholarship. Newspaper notices of the dance explained "Doctor's Day" and pointed out that under our system of individual freedom America has attained standards of medical care which are the hope of the world. Another Auxiliary, the Baltimore City, chose Doctor's Day to initiate a Medical Scholarship Fund. The Auxiliary to the Washington County Medical Society obtained radio "spot" announcements, on March 30th, which were broadcast every fifteen minutes day and night. These broadcasts consisted of anecdotes and of quotations from literature expressing appreciation of the physician's contribution to society. Also, the Hagerstown newspapers published the Hippocratic Oath and Stevenson's "Ode To A Doctor" in honor of the occasion.

Our 1952 Doctor's Day publicity might begin with the remarkable history of the Medical and Chirurgical Faculty of Maryland which was founded in 1799. The Faculty created the School of Medicine of the University of Maryland, one of America's oldest and finest medical schools. In 1848 it played host to the first Annual Convention of the A. M. A. Today the

Faculty offers many services which should be brought to the attention of the public. One such service is the emergency call telephone exchange which makes it possible to always reach a doctor in time of need. Also there is the Professional Conduct Committee which functions as liaison between doctor and patient. The failure of the public to avail itself of the health services offered by the Medical Societies ought to be mentioned. For instance, when extreme claims are made for certain foods, drugs, diets or exercises, the average citizen takes the word of some untrained, self-styled "expert." The Medical Societies on the other hand are a source of authentic information on health matters, and the Auxiliary has an opportunity to point this out in Doctor's Day publicity. Auxiliary members can always write in to their Medical Societies, to the A. M. A. or to "Today's Health" (the A. M. A. magazine) to check up on health rumors. They would then be able to give correct data to their friends, and would be teaching their communities to use the Medical Societies as they should be used. Finally, Doctor's Day publicity ought to stress the fact that in addition to his practice, his personal medical charity, his public medical education work, and his support of hospital and health drives, the doctor of today still finds time for civic enterprises, whether cultural, charitable or religious.

As background material for the use of our Component Auxiliaries, I have written, compiled or obtained the following papers: "Notes on the Origin and Development of the Medical and Chirurgical Faculty"; "The Medical and Chirurgical Faculty and the Public"; "The Relationship of the A. M. A. to the Public"; "The Doctor as a Citizen"; "The Hippocratic Oath" and Stevenson's essay, "The Doctor." Let's use all of the mediums of publicity including television, where it is available.

Events which might be held on Doctor's Day include benefits for nursing scholarships, essay contests on the accomplishments of American Medicine under political freedom, and public meetings with a speaker.

At the present time, when for political reasons, our doctors have been made the object of much offensive propaganda it is our pleasure on Doctor's Day to remind ourselves and others of an "eternal verity"—the dedication of a doctor's life to his fellow man!

CREATIVE ARTS SHOW

MRS. BEVERLEY C. COMPTON, *Chairman*

Once more the Woman's Auxiliary to the Medical and Chirurgical Faculty has been requested to put on an art show. This idea was first inaugurated at the Annual Meeting of the Medical and Chirurgical Faculty in April 1951, with considerable trepidation by all concerned. Previously the meetings had been all business and no frills. Many were dubious about the outcome. However, the Arts and Hobby Show of 1951 was a great success with 38 doctors and 12 wives showing a wide variety of skill in many fields, including painting in several mediums, photography, sculpture, ceramics, weaving, furniture making and other interesting and surprising exhibits. The Show was well attended. The library was transformed into an art gallery by the use of large wooden screens, which gave plenty of continuous well-lighted hanging space, and which concealed but did not disturb the Library's permanent pictures. Showcases were borrowed from other parts of the building. The result was excellent and surprisingly professional.

Everyone was so enthusiastic that now we are planning to present the Creative Arts Show of 1952 from Monday, April 28th through Wednesday, April 30th. The Show will be limited to exhibits actually made by the exhibitor. There is so much hidden talent among the doctors and their wives that this year there will not be room for any collections. Entries are already coming in, and we are glad to welcome those who showed last year as well as new exhibitors.

Entries are to be delivered to the Medical and Chirurgical Faculty building, 1211 Cathedral Street, Baltimore, on Wednesday and Thursday, April 23 and 24, 1952. Exhibits may not be removed from the Show until after the Wednesday evening meeting April 30th, or any time on Thursday, May 1st. A hostess will be in attendance with the Show on the days it is open. The Medical and Chirurgical Faculty cannot carry insurance on your exhibits. However, utmost care will be taken of them, and possibly your own policy will cover them. Please write to Mrs. Beverley C. Compton, Lake Station, Ruxton 4, Maryland (telephone—Towson 7090), stating what your entries are and the approximate size.

Ancillary News

BALTIMORE CITY DENTAL SOCIETY

A. BERNARD ESKOW, D.D.S.

The Baltimore City Dental Society held its annual All Day Meeting on February 11 at the Lord Baltimore Hotel. The morning session was devoted to a Symposium on "The Health of the Dentist." The physicians participating were Perry MacNeal, M.D., Associate Physician to Benjamin Franklin Clinic & Pennsylvania Hospital, who discussed "Common Medical Diseases Affecting the Dental Profession"; Jesse T. Nicholson, M.D., Professor, Dept. of Orthopedics, School of Medicine, University of Pennsylvania, whose topic was "Postural Strains Encountered in the Practicing Dentists"; Joseph B. Vander Veer, M.D., Assistant Professor of Clinical Medicine, University of Pennsylvania, who discussed

"Important Cardiovascular Diseases"; and finally Joseph Hughes, M.D., Professor of Psychiatry, Woman's Medical College of Pennsylvania, whose topic was "Common Psychiatric Problems Met in Dental Practice."

A luncheon followed at which the guest speaker was Raymond Moley, one of the contributing editors to the magazine *Newsweek*, who discussed some of the political and sociological trends occurring in the country today.

The afternoon was devoted to registered clinics discussing various phases of dental techniques and given by outstanding men in their field.

THINK OF THIS!

Contributed by Dexter L. Reimann, M.D.

There is such an infinity of tests in these days that the student could easily devote all his time to the apparatus and technique of medicine and forget that the patient is a person. Whitehorn, J. C.: Basic Psychiatry in Medical Practice.—J.A.M.A., 148: 332, 1952.

Letters to the Editor

Telegram
February 1, 1952

Hearty congratulations to you, Editorial Board, and special praise for the help of the office force. The new infant Journal will be a progressive and instructive force in the good work of the Faculty. To you and all "ad multos annos."

J. Albert Chatard, M.D.

February 4, 1952

Dear Dr. Yeager:

I have just finished reading the new "Maryland

Journal," and I must extend my congratulations.

Such a publication will certainly promote a better understanding among component societies and make each physician feel that he is an integral part of the State organization.

May I also offer the congratulations of the Baltimore County Medical Association and pledge its support.

Sincerely,

CHARLES H. WILLIAMS, M.D.,
President Baltimore County
Medical Association

THE HOSPITAL STANDARDIZATION PROGRAM

The appointments to the Joint Commission on Accreditation of Hospitals and the various organizations which they represent, have been announced:

American College of Physicians

Alexander M. Burgess, M.D., Providence,
Rhode Island

William S. Middleton, M.D., Madison, Wisconsin

LeRoy H. Sloan, M.D., Chicago, Illinois

American College of Surgeons

Arthur W. Allen, M.D., Boston, Massachusetts

Evarts A. Graham, M.D., St. Louis, Missouri

Newell W. Philpott, M.D., Montreal, Quebec

American Hospital Association

Edwin L. Crosby, M.D., Baltimore, Maryland

Judge Milton George, Morden, Manitoba

John H. Hatfield, Philadelphia, Pennsylvania

Right Reverend Monsignor J. J. Healy, Little
Rock, Arkansas

A. J. J. Rourke, M.D., San Francisco, California

Charles F. Wilinsky, M.D., Boston, Massachusetts

American Medical Association

Gunnar Gunderson, M.D., LaCrosse, Wisconsin

L. W. Larson, M.D., Bismarck, North Dakota

Julian P. Price, M.D., Florence, South Carolina

Stanley A. Truman, M.D., Oakland, California

Herman G. Weiskotten, M.D., Skaneateles,
New York

Rolland J. Whitacre, M.D., East Cleveland,
Ohio

Canadian Medical Association

E. K. Lyon, M.D., Leamington, Ontario

(A. D. Kelly, M.D., Toronto, Ontario, Alternate)

The Joint Commission held its first meeting on Saturday and Sunday, December 15, and 16, at the Drake Hotel in Chicago. Further details concerning the plan for the Joint Commission on Accreditation of Hospitals have been published in the Bulletin of the American College of Surgeons, 40 East Erie Street, Chicago, Ill.

TAX RELIEF PETITION

If you have not seen or signed this form, ask your Medical Society President about it!

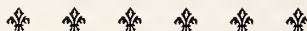
It has long been the feeling of doctors and other professional people that the present income tax laws, both state and federal, are very inequitable and unfair to groups requiring a long and expensive period of training.

A Committee for the Study of Certain Phases of Medical Economics has been appointed by the Medical and Chirurgical Faculty of Maryland to study this problem. The members feel that very little can be accomplished without the support of the component medical society members and others facing the same problem. The Committee proposes that the Medical and Chirurgical Faculty, in conjunction with other interested groups, prepare and sponsor a bill, incorporating the following ideas, to be presented to the Maryland Legislature at the 1953 session.

1. The cost and compensation for time lost during the training period be deductible from income tax over a suitable number of years.
2. Postgraduate and advanced training be deductible.
3. Setting up of a retirement plan taxable only on payment, which would allow an individual to prepare during his active years for his declining years.

Starting this at a State level is probably the only way to effectively bring the problem before Congress at a national level.

If you are in accord with the above ideas and would like to help in solving this problem, please get in touch with the President of your Medical Society.



FAREWELL DINNER TO ALAN F. GUTTMACHER, M.D.

The Obstetrical and Gynecological Society of Maryland and the Sinai Hospital Staff will tender a farewell dinner to Dr. Alan F. Guttmacher in May. All members of the Society are invited.

Dr. Alan F. Guttmacher is a former President of the Obstetrical and Gynecological Society; Chief of the Department of Obstetrics, Sinai Hospital; Chairman of the Baltimore Rh Laboratory since its establishment; representative of the Faculty on the Blue Cross and Associate Professor in Obstetrics, Johns Hopkins Medical School and Hospital. Dr. Guttmacher is leaving Baltimore to become Director of Obstetrics and Gynecology at the Mt. Sinai Hospital in New York.

The exact place and date of this dinner will be announced later. The Committee in charge of arrangements consist of Dr. Louis H. Douglass, Chairman; Dr. Nicholson J. Eastman, Dr. I. A. Siegel and Dr. David Silberman.

Maryland

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EDITORIAL

A GOOD DOCTOR IS A GOOD CITIZEN

The physician who consistently fails to attend hospital staff meetings, or who takes no active part in the affairs of his Medical Society, is hardly in a good position to criticize either the hospital or the Medical Society. By failing to make his voice heard, he must share the blame for any faults, failures or deficiencies.

Likewise, the physician who fails to *register* and *vote* is not in a good position to complain about corruption, taxes or Governmental policies which he finds obnoxious. By failing to fulfill one of the vital duties of citizenship, he must share the blame for any black spots in the affairs of the community, the State or the Nation.

The right to *register* and *vote*, which is both a privilege and a duty in a Nation of free men, was never more important than it is right now. Fundamental issues which transcend the usual party politics, and which will affect the future of every American, call for a clear-cut decision by the entire voting population. Be sure that you play your rightful part in that historic American decision.

To be a good doctor—first be a good citizen.

Register and then *Vote*. And of equal importance, see that your family does likewise.

DON'T BE DERELICT!

The late Justice Oliver Wendell Holmes once said that a man must take part in the action of his times, lest he be judged not to have really lived.

In this critical election year of 1952 we might paraphrase that statement to say that every physician must register and vote, lest he be judged derelict in his duty as a citizen.

The vast majority of physicians are deeply conscious of their responsibilities in the care of the sick and injured. It is imperative now that they become equally conscious of their high duties as American citizens. This year of decision on vital issues requires the fullest possible expression of opinion by the largest possible number of qualified voters. Physicians, as members of an educated, thinking, professional group, must help set an example to bring that about.

So, regardless of your political viewpoint or party affiliation, *register* and then *vote*—and urge your family, friends and patients to do likewise. This is a duty which you owe to your profession, to your community and to your country. *Don't be derelict in that duty!*

Reports

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee for the Study of Pelvic Cancer met in the Small Hall of the Medical and Chirurgical Faculty Building on February 21, 1952, from 5-6 P.M.

CASE DISCUSSIONS

Case I. Discussion of this case was deferred until the next meeting as the physician concerned was ill and unable to attend the meeting.

Case II. E. J. Colored. Age 50. Married. Para 5, 1 miscarriage. Beginning about September 1951, excessive flow at time of menses and intermenstrual spotting. Bleeding later became almost continuous. Consulted doctor A, October 1951:—was given oral medication and “needles” once a week for several weeks. Hospitalized January 1952, for D. & C. Biopsy showed carcinoma and patient was referred to second hospital for treatment. X-ray. *Diagnosis:* Squamous cell carcinoma of cervix, I. C. III a.

Chairman: Doctor A was unable to attend the meeting today but we have received the following information from him: “This patient was seen on the 24th of February 1951 with the complaint of menorrhagia of two weeks duration. She was given 40,000 units of estrogenic hormone and an RX for diethylstilbesterol, 5 mgm. t.i.d., tablets 12, and told to return for a pelvic examination as soon as she stopped bleeding. She returned on May 19, 1951, with the same complaint of menorrhagia of two weeks duration. She was advised to come back as soon as she stopped bleeding. She returned on the 31st of May 1951. At that time speculum examination revealed a small suspicious area on the cervix and the uterus was slightly enlarged. Hospitalization for biopsy and D. & C. was advised, but refused. She was seen again on November 21st, 1951 for La Grippe. Fluoroscopy at that time revealed a tumor mass in the right chest. Patient said that she knew of this for the past two or three years. She received penicillin on the 29th of November, 6th of December and the 24th of December, 1951. She returned on

January 9th, 1952, again with the complaint of menorrhagia. She was advised to go to the hospital and was hospitalized on the 15th of January, 1952. At that time biopsy of the cervix revealed carcinoma. She was referred to another hospital for radium therapy.”

This physician seems to think that bleeding is a contraindication to a pelvic examination. To my mind this is no reason for postponing an examination. It is often the best time to examine a patient in order to determine where the bleeding is coming from. In this case the complaint was irregular and excessive bleeding and a pelvic examination was indicated whether or not the patient was bleeding.

Is there any discussion of this case ?

Committee member: Was radium used in the treatment of this patient ?

Committee member: Not to date because of the terrific extent of infection.

Committee member: Here again we have a case of a patient being treated with estrogenic hormones and a pelvic examination not done.

Chairman: This would seem to be a case of physician delay because a pelvic examination was twice deferred because of bleeding. There was also obvious patient delay.

Case II—Patient and physician delay.

Case III. M. K. White. Age 69. Widow. Para 5, two miscarriages. Menopause between 55-57 years of age. Many episodes of cystitis over the past four years. Occasional spotting over the past two to three years. During this time under care of doctor A, for treatment of hypertension and frequent bladder symptoms. Pelvic examination said to show an “irritated place on cervix”—biopsy not taken. Consulted doctor B, August 1951—was examined—referred to hospital clinic and hospitalized. *Diagnosis:* Squamous cell carcinoma of cervix, Stage I. Treated with radium and x-ray. Readmitted to hospital January 1952, with complaint of abdominal pain and distention. Operation: Exploratory laparotomy—Cholecystolithotomy—Biopsy of liver. Biopsy of the liver showed liver involvement.

Chairman: We are sorry that doctor A is unable to be present today. By telephone we have received some notes from his records on the patient. He has seen this patient at fairly frequent intervals over the past several years. The patient's chief complaint was hypertension and she also had many episodes of cystitis. I.V. pyelograms in 1949 were negative. Pelvic examination was made November 18, 1949, when patient complained of vaginal bleeding. This examination said to be negative except that the cervix bled easily. D. & C. was advised but the patient did not wish to have this done. Douches were prescribed. When the patient was seen in January, 1950, she stated that she had had no further bleeding and she was not again examined. The patient continued to consult doctor A at rather frequent intervals—the last visit on July 6, 1951, with a complaint of cystitis. There was no further note of complaint of vaginal bleeding; no pelvic examination except in November of 1949.

Committee member: This is the second case we have had where D. & C. was recommended but refused by the patient. This seems to bring up the question of how strongly the D. & C. was, or should be, urged. If a patient is made to realize that this is important, not many of them will refuse.

Chairman: Certainly it is a rare thing for a woman on whom I have recommended a D. & C. to refuse. Once in a while a woman will say it is not convenient, etc., but an explanation, increasingly blunt if necessary, will usually persuade her to have it done.

Visiting surgeon: I would like to ask if there was any contraindication to a Wertheim in this case?

Visiting surgeon: Yes, the patient was obese, elderly and hypertensive.

Chairman: I believe even Dr. Meigs would consider this sufficient contraindication to a Wertheim.

Visiting surgeon: This case was interesting to us for several reasons. When the patient was first seen in August the lesion appeared to be entirely confined to the cervix. She was treated by two insertions of radium, followed by deep x-ray. She appeared to have a very good result. She returned to the hospital in January with acute pain and a mass in the upper right quadrant. It was decided it was necessary to do an exploratory laparotomy. At this time the pelvic organs felt normal—we were unable to feel any involvement and no palpable glands. Liver biopsy taken at this time showed carcinoma compatible

with the original carcinoma. Although the classification was originally Stage I, as it developed it should have been Stage IV. Even at the time of her admission to the hospital in January, the cervix showed no evidence of recurrence.

Chairman: This is another case of a hypertensive patient with vaginal bleeding. There is a good deal of mention in the British medical literature of so-called "apoplexy of the endometrium." Whether or not in this case it was considered a possible cause of the bleeding we do not know. I do not put much stock in this and certainly no doctor should assume that bleeding is due to hypertension. In one study that was made of unexplained post-menopausal bleeding the suggestion was made that hypertension might be an explanation. On looking over the histories I found the average blood pressure was below normal in all of these cases.

There was some discussion of hypertension and vaginal bleeding, and whether or not this was a category in which patients could be classified when vaginal bleeding seemed otherwise unexplained.

Chairman: It seems that we cannot rule this case physician delay because a D. & C. was suggested and refused.

Case III—Patient Delay.

Case IV. E. R. White. Age 54. Sep. Para 8. Menopause at 38 years. June 1951, patient noticed slight bleeding which she thought was from hemorrhoids. At this time she was under care of doctor A regarding "lump in throat." Told him of the bleeding—was given salve for hemorrhoids but was not examined. Hospitalized August 1951, for excision of submaxillary gland, left, for calculi with infection. Routine physical at that time noted "small bleeding point on anterior surface of cervix"—"cervical bleeding should be looked into." Discharge summary August 27, 1951 notes "pelvic essentially negative except for cysto-urethrocele and rectocele." Referred from surgery to gyn. clinic September 12, 1951—hospitalized September 17, 1951. Radium and x-ray. *Diagnosis:* Epidermoid carcinoma of cervix, I. C. Stage I, early.

Chairman: Although this patient's complaint was bleeding "she thought was from hemorrhoids," she should have had an examination. A patient often does not know whether she is bleeding from the vagina or rectum. In either case an examination is indicated. When in the hospital the patient was on the surgical service and although it was noted that she was having vaginal bleeding there was no gyn. consultation. The patient was referred to the gyn. clinic after her discharge from the hospital.

Committee member: There was actual delay here of only two weeks from the time the patient was examined in the hospital and the time she was referred to the gyn. clinic. By a technicality the surgeons get under the wire because of our arbitrary ruling of "delay" as a lapse of one month. Certainly a gynecological consultation should have been made on the ward before the patient was discharged from the hospital.

Visiting surgeon: This patient was admitted to the hospital for a minor operation. It seems to me the surgeons should be complimented for having done a pelvic examination in the routine physical.

Visiting surgeon: I would like to mention that every female patient (ward) coming into our hospital on the medical service is given a pelvic examination by a member of the gyn. staff.

Case IV—Physician Delay.

Case V. E. E. Colored. Age 28 years. Married. Para 0. October 1950, patient under care of doctor A because she was overweight. Pelvic examination made at this time; patient told she either had a tumor or was pregnant. Friedman test negative. Menses continued normal until March 1951, missed April and May and abdomen became very much enlarged. Consulted doctor A—was examined; was told he did not know whether or not she was pregnant. Because of differing opinions patient decided to go to hospital clinic June 1951. First seen in gyn. clinic, thought to be pregnant and referred to O.B. clinic where she was examined and told she was pregnant. Because of vaginal bleeding patient returned to O.B. clinic late in June. At this time it was decided that she was not pregnant and she was referred back to gyn. Medical work-up during July; admitted to hospital July 23, 1951. Laparotomy revealed extensive involvement of all abdominal organs; because of patient's condition it was not possible to remove pelvic organs at this time. X-ray treatments August and September. Operation January 1952: Panhysterectomy; bilateral salpingo-oophorectomy.

Diagnosis: Papillary carcinoma—ovarian origin (right)—metastatic.

Chairman: This seems to be a case where the patient was fighting to get a diagnosis. I do not believe we can be too critical of the men who saw the patient on the outside when there was considerable delay in getting a diagnosis after the patient came to the hospital.

Visiting physician: This case was particularly confusing to us because the patient's menstrual history showed that she had missed a period at various times. When seen on September 19, 1950 she gave a history of scanty menstruation for two days, then

menstruation again fifteen days later, then at the time due again she had a regular period. At this time she was complaining of being tired and "let-down." Friedman test was negative for pregnancy. She went along normally until March but missed a period in April. On April 13, 1951, the uterus was slightly enlarged and she was complaining of pain in the right lower side with dysuria. I recommended bed-rest for two to three weeks. When the patient was seen again I was still uncertain as to whether or not she was pregnant. The uterus seemed too much enlarged for the probable length of the pregnancy. Another pregnancy test was advised but this was not done. The patient then consulted another physician and was assured that she was pregnant. I did not see her again until after she had been to the hospital clinic and she came back to us because she was dissatisfied with the treatment she had received. I advised her to stay with the hospital. Frankly I did not know about this patient. The tumor did enlarge relatively rapidly and the growth was too fast for a fibroid.

Data was given from the hospital history and operative notes. Friedman test done in the hospital in June reported negative.

There was discussion of the difficulties in diagnosing carcinoma of the ovary—one of the doctors calling it "the biggest challenge in gynecology."

Visiting surgeon: Would you elaborate on your statement in regard to waiting in the case of adnexal enlargement?

Chairman: If the enlargement is golf-ball size or egg-size and there is a question whether it is malignant or a retention cyst, you might follow this case for a time, possibly a month. If it is a retention cyst it will disappear. When you are sure you are dealing with a neoplasm of the ovary, you had better get in. If it is part solid and part cystic, you had better get in. If otherwise, you will be justified in waiting for a while.

The case under discussion is obviously one in which the diagnosis was difficult. We should consider whether or not the physicians did all that was possible in order to arrive at a diagnosis. The patient was first seen in the hospital on June 13, 1951 and was not hospitalized until July 23, 1951.

Case V—Institutional Delay.

Case VI. B. S. Colored. Age 49 years. Married. Para 0. September 1950 excessive vaginal bleeding for 2-3 days.

Following this menses more frequent—some intermenstrual bleeding and post-coital spotting occasionally. Consulted doctor A, September 1950. Pelvic examination was made. Patient told she had a “fibroid” and was beginning the menopause. Consulted this doctor about once a week. Was referred to hospital, December 1950. *Diagnosis:* Squamous cell carcinoma of cervix, Clinical Stage I. Radium and x-ray.

Chairman: A pelvic examination was made in this case but the presence of a “fibroid” does not explain the bleeding, especially with post-coital bleeding. We do not know what treatment the patient received, if any, while under the care of doctor A. It appears that further examination should have been made or the patient referred to the hospital. There is apparent delay of three months.

Case VI—Physician Delay.

Case VII. A. P. White. Age 38 years. Married. Para 2. Artificial menopause May 1944 (supravaginal hysterectomy). November 1950 patient consulted doctor A with complaint of dysuria and frequency. Pelvic examination at this time was negative. Cystoscopy revealed urethral stricture requiring treatment until March 1951. December 1951, post-coital bleeding. Consulted doctor A—was examined—hospitalized for conization of the cervix. Re-admitted to hospital December 31, 1951. I.V. pyelograms negative—x-ray examination of colon, negative. Attempted radical Wertheim January 9, 1952. Radium. To have x-ray following discharge from hospital. *Diagnosis:* Immature to medium ripe squamous cell carcinoma of cervix, Stage II.

Chairman: Is there any discussion of this case?

Visiting surgeon: At the time of conization was the tissue examined?

Guest surgeon: Yes. It showed immature to medium ripe squamous cell carcinoma. The further studies as indicated on the abstract—the I. V. pyelogram, x-rays, etc., were done in preparation for a radical Wertheim. At operation it was found that a Wertheim could not be done.

Chairman: Certainly there is no criticism of the studies done in preparation for a radical Wertheim but why should a radical Wertheim be attempted in a Stage II?

Guest surgeon: It was felt that this was a suitable case. It was an early Grade II, the patient weighed ninety pounds, there was no evidence of metastasis and we did not expect too much technical difficulty

in the operation. I feel that in selected cases Stage II's are suitable for Wertheim.

Visiting surgeon: Meigs states that the ideal radiation treatment is not yet found and so he attempts operative procedure. His reports are good on Stage II A (I. C.)

Committee member: Meigs' actual figure in Stage I, 85 cases, is 80%. Including Stage 0 cases it is 88%. Figures in the Stage II group (selected cases only) are in the 60's. If all Stage II cases were included the figures would be very different because there is a great difference in a Stage II where the tumor goes to the pelvic wall and in a II with a little extension to the vaginal vault. Our figures, including all Stage II's show about 40% salvage in II's treated with irradiation. It is difficult to compare figures because of difference in classification in different clinics.

There was considerable discussion of the Wertheim and Brunschwig type of operation. Those defending the radical operation pointed out that the doctors of today are able to do a more radical operation than in the “old days” because they have more to work with and more aides in the way of antibiotics, transfusions, etc.

The question was raised as to what should be done in the case of radio-resistant carcinoma. There was some discussion of cases and the consensus was that radio-resistant I's and a few selected radio-resistant II's were suitable for radical Wertheim operation.

Case VII—No Delay.

STATISTICS

Patients Interviewed to February 19, 1952..... 98

Classification:

No Delay	29
Patient Delay.....	36
Physician Delay	10
Patient & Physician Delay.....	7
Institutional Delay.....	1
Patient & Institutional Delay.....	1
Asymptomatic Detected Cases.....	2
Unclassified to date.....	12
	—
	98

NO LONGER OUR IVORY TOWERS*

NEWLAND E. DAY, M.D.

The "Great" of Medicine, in the past, were able to hold themselves somewhat aloof from the roar of currents and tidal waves that seemed sometimes to engulf the average laity, and yet pass by the profession with but a ripple of disturbance. There was a mystic relationship between doctor and patient, then, that had to do with roots of understanding; heritages of faith, that were based upon an almost unshakable belief (perhaps not always, but almost always justified) that "our Doctor" was infallible! In turn, the doctor could, in almost all instances where he had shown good faith, count on the loyalty of his people, and know that, when the "chips were down," he and his patient stood shoulder to shoulder against forces of evil seeking to destroy that bond. His patients deserved the best he could give them regardless of their ability to pay. Public appreciation of that relationship and of his status in his community thereby was a form of compensation that kept a doctor from feeling the rub of poverty even when he lived with it and in it. He was therefore less perturbed by the surge of economic and political forces than had he been engaged in some other profession.

But time and events have forced doctors to take another look at themselves and their relationship with their patients or "public"! Though the doctor has been content to drift along wearing the time-honored medallion of "Public Service," unaware that the shine of past services is becoming dulled by carelessness, political and economic winds have arisen blowing an increasingly corrosive dust to dim that medallion in the public eye. An era of discontent has begun and the intangibles of public service are no longer mentioned. "Great Words" are being used (or misused to suit the purpose) to introduce a radical change, from those philosophies which have made this Country great, and which are symbolized by the statement that "Man lives not by bread alone," to blunt National policies that scoff at this and say "Man Does Live By Bread Alone." An attempt has been made to reduce our nation to

that animal status under which the one factor of importance is "our bread" and under which nothing else matters. This is a state in which the individual's income will be determined by his needs rather than by his contributions to society.

The shock of "The Depression" failed to make doctors aware that they were no longer protected by an "Ivory Tower" from the twists and turns that men's minds will take when hunger is astutely used as a lever. Nor did they realize that the fear of illness and its costs plus the panic of unemployment was being used to threaten man's very sanity.

Caught up in the pre-war and wartime urgency of "a big job to be done," doctors became too busy to notice that these forces had never let up but that the strangulating net was being drawn tighter over everyone in the guise of patriotism, and that every time he became careless or indifferent to the financial problems of his patients he was helping his detractors carry out their "plans of organization."

About 1948 doctors awoke with a start to the realization of what was transpiring and with some of the panic which they had sometimes failed to recognize in others. No longer were there innuendos suggesting that a change was going to be made. Now there were front page pronouncements that the National Administration had committed this Nation in its platform to a program of compulsion comparable only in its scope to those established in completely totalitarian, collectivized countries. Guess who was involved this time! Though it had been going on all around him: public utilities, the farm, etc., socialistic tentacles were reaching for the doctors. "Ivory Towers" no longer appeared to be a haven for retreat, but rather had become a target for the malicious who charged that the Towers of Medicine represent not "service but whitewash."

However doctors come in daily contact with, and are inherently geared to deal with crisis, and indeed are apt to function better once they realize what the crisis is about or that one exists.

Let us see what has been done since 1948, as manifestation on the part of doctors that they must

* Submitted by the Committee on Public Medical Education, Baltimore City Medical Society.

re-establish a satisfactory doctor-public (patient) relationship. How can the doctor be accorded that respect so essential to the successful conclusion of his professional duties? What has happened to permit a closer and warmer contact with the patient and to make the patient realize that he and his doctor still do have a common heritage of faith? What has renewed the belief that "that nation is governed best that is governed least"?

Doctors again have become citizens! They have recognized and are using the power of Truth. The narcosis of the sedative administered by the proponents of "Free" or Compulsory Medicine could only be overcome by the powerful stimulant of "Truth." So doctors have taken the true story to the Nation. When they began, only one organization was on record in Congress as being against Government Medicine. Today, over 15,000 organizations representing millions of people have thrown down the gantlet of protest in such a way that even the most power-hungry cannot overlook it.

Having become civic conscious, we realize now that this is not just a fight of the profession for itself, and not just a fight against a system of foreign instigated compulsion. We must re-educate the public to the fact that the American Medical Profession maintains a constant vigilance over the Health and Welfare of our nation in a manner to guarantee their *protection* and not their subjugation. We must point out the fact that a GREATER EXTENSION OF VOLUNTARY MEDICAL CARE GIVES A MAN PROTECTION BUT LETS HIM KEEP HIS PRIDE. We in Maryland, under the sponsorship of The Faculty initiated a program for the care of the "Medically Indigent."

Concentrating on the problems of the most needy, caused some delay in tackling the problems of the so-called middle income or white collar groups. The

latter groups are now protected against catastrophic illness along with the lower income group through the extension of Blue Cross and Blue Shield or Medical Service programs.

Public service and public relations have been improved through the establishment of city, town and country *Emergency Medical Services* or *Emergency Call Exchanges*. The lack of any such organized program had previously been a source of public irritation which had been increased by a few unfortunate circumstances attracting bad publicity. This service may stand us some day in great stead in the event of public disaster.

A Faculty grievance committee has been established. The existence of such a committee has helped to raise the public estimate of the value of this State Society. In connection with this service, our Committee for Public Medical Education recommends wider publicity on the existence and work of the State Committee on Professional Conduct.

In cooperation with the Committee on Public Medical Education the Woman's Auxiliary to The Medical and Chirurgical Faculty has been most active and has manifested limitless energy in its support of the fight for Medical Research popularly known as the "dog fight." The Auxiliary has had Health Booths at County Fairs, etc., in support of the "American Way of Life" and have supplied excellent speakers for various occasions. In addition, it has spread an enormous amount of good will for the profession as an organization interested in health problems.

Finally, the American Medical Education Foundation, of which there is a local cooperating committee, is one more proof positive that the doctors are working to assure a sound doctor-public relationship, as well as a supply of young doctor graduates from academically free institutions of learning.

NEED FOR PHYSICIANS

A survey shows that the 65,000 people of Frederick County are dependent on no more than 20 resident physicians in general practice. Officers of the Frederick County Medical Society composed a Steering Committee, which has made a detailed study of the availability of medical care at present and in recent years. Added to the 20 general practitioners living in the City and County, the report stated that there are 10 more from borderline communities and other counties, who use local hospital facilities and number some Frederick Countians among their patients.

Scientific Papers

THE PHYSICIAN AGAINST ATOMIC ATTACK¹

WILLIAM L. WILSON, M.D.²

Wherever one turns, varying degrees of anxiety exist over the possible lack of reasonable security against threats of atomic attacks by an enemy, with or without a warning to the population. Whether or not such a fear may be justified, that our cities might be subjected to atomic or other modern attacks, cannot be asserted positively. Nevertheless, the potentialities are known to be present. What is sure is that people have always accepted such a challenge to their survival in the past. They have met with relative success in their efforts towards that survival. However, now as in the past, people have a right to demand and must have proper leadership for their efforts. There is nothing new in this situation due to atomic bombs.

Someone has said that twenty-three hundred years ago Aristotle wanted a city of a type where one could work effectively and which would be hygienic, attractive, and readily defended. How little some circumstances have changed! But how much others have started us on a tight-rope race for survival! Two recent world conflicts have been decided favorably by this Nation, where people could work effectively, where our industrial production supported our own and allied fighting forces in such a manner as to make our cities readily defended, hygienic and attractive. American people may continue to work effectively, but only if their cities may be readily defended in the future. That is why a future enemy likely would strive initially to

cripple American industrial production by all-out direct attacks upon our cities. Therefore, if we should not make our cities as easy as possible to defend readily, citizens could not work effectively during and after attacks, the cities would not be attractive, and they probably would not be hygienic. One must agree that a sense of some readiness for defense would promote mental health for workers whom we would ask and expect to continue on the job despite enemy attacks or threats.

Our own recent Federal Civil Defense Act of 1950³ reiterates the age-old truths just mentioned. It defines "civil defense" in a manner indicating the priorities to be given to minimizing the effects upon the civilian population caused or which would be caused by an attack upon the United States, to dealing with immediate emergency conditions which would be created by such an attack, and to repairing or restoring vital utilities and facilities destroyed or damaged by any such attack. A physician should and does sense immediately his potentially essential part in the survival of the Nation if attacked.

Human life and productive skill cannot be replaced readily. This is a matter of major importance to us where the numbers of our people are limited, where their skills increase and capabilities are highly specialized only after long, carefully directed training, and where they are concentrated into densely populated areas of unbelievable vulnerability to attacks. Other nations of more people, less skilled, carry less risk. As critical as material damage to our cities could be, under the circumstances, the truly precious factors which we must preserve are life, health

¹ William Royal Stokes Memorial Fund Lecture, presented under the title of "Bulwark of the Nation—The Physician Against Atomic Attack," at the Annual Meeting of the Medical and Chirurgical Faculty, April 24, 1951.

² Colonel, Medical Corps, United States Army, Special Assistant to The Surgeon General.

³ Public Law 920, 81st Congress, 2d Session.

and effective production. The immediate, deepest and most understandable concern of all of us in the presence of a disaster would be for the health and safety of our wives, children, loved ones, relatives and close friends. Maintenance of full civilian industrial support of a future war effort therefore depends upon our ability to preserve maximum physical and mental health of civilians or restore it where interrupted. That is why the physician is the bulwark of this Nation, why the physician has been, and must continue to be, a leader in every community preparation for survival from any damage an enemy could devise or direct against us.

Physicians may have pardonable pride in their past foresight leading to medical preparations for atomic attacks, preceding non-medical preparations of others in this country. Eleven years ago it was civilian physicians who first foresaw the need for a national civilian medical organization to care for our own civilians if subjected to enemy attack. Nearly five years ago, when others were not actively engaged in such matters, one of our highest military medical authorities sponsored development of national methods for integrating military with civilian administration of health services of the Nation for war, if it should come. Four years ago, the medical profession established the Council on National Emergency Medical Service of the American Medical Association leading to prompt, earnest development by the profession of methods by which physicians could support the Government in a National emergency. Soon after that the Public Health Service and State health authorities undertook the problem with equal confidence and ability. More recently, physicians grouped or banded together in practice for great good, have aligned thousands of citizens, or prepared them for aiding, in civil defense operations. As an example, physicians of one of our church denominations have initiated an organization and the training of its whole membership, while the Medical Correctional Association, through the American Prison Association, has stimulated a civil de-

fense program for many thousands of prisoners. We need go no further to substantiate medical leadership of the past in developing community civil defense.

Immeasurable future contributions of time, thought and effort, and many and great additional sacrifices by the medical profession will be required, if physicians are to maintain necessary levels of health in the population they have always served so faithfully. It is readily understandable that the questions most physicians want answered now involve the manner in which they may serve, and when and where. These are questions which will not be answered in detail at this time by one individual, governmental agency, or group. They are questions the answers to which are influenced by every family and every home. The medical profession cannot solve the problems alone. Nevertheless, physicians can, and their leadership must, participate in the solutions while and as they are being developed, in order to maintain the health of the family and the significance of the home to the maximum practicable degree. Community physical and mental health, along with a desirable level of moral standards depend upon this, the public's confidence depends upon it, and desirable social effects of our preparation for civil defense, as well as any operations which might be required in the future, depend upon it.

At this time physicians do not need and, therefore of necessity should scrutinize, any detailed organization, manning and equipment specifications and prescribed procedures which would be forced upon them. Indeed, in the preparation phase for civil defense, the Federal Act depends upon voluntary participation by all citizens, in their own communities. Without this, the law alone cannot produce success. Wherever he has not already done so every physician should do four things:

1. He should learn the law.
2. He ought to search out and learn the local overall organization, its direction, and its nature, for civil defense.

3. He should join in local professional development of civil defense medical plans commensurate with the local overall plans.
4. Finally, through the professional organizations of the communities' physicians he should contribute to the development of Federal, State and local medical civil defense, and to its support by aiding in recruiting and training countless thousands of non-professional volunteers, without which medical success is unlikely.

In recent months it has been stated frequently that physicians are so far ahead of others in civil defense that they can do little now except wait for detailed manuals or additional guides in order to organize medical units. Nothing could be more short-sighted, or further from safety if such a concept were to be accepted. Federal guides and manuals will be developed and promulgated. But, they should be prepared only after all-round consultations leading to proper relationships visualized by the Federal Act to exist between Federal, Regional, State, and local authorities and between various civil defense services. The physician must understand not only these relationships but also the timing of measures to be undertaken, as well as the phase applicable at any one time. The law defines the measures to be taken in preparation for anticipated attack, during attack and following attack, as it does also organizational equipment, materials and facilities. Thoughtful persons will realize that local application of these concepts according to a national pattern cannot and must not be achieved over night by so complex a social order as ours is, unless we are to accept potentially undesirable or even irreparable damage from ill-advised and stop-gap social policies.

Once we understand our respective missions all of us must follow a uniform program in our development of plans. It is true that the uniformity must follow a leadership of National origin. As we desire such leadership we must recall that this was established by law less than four months ago. As we wait, we may gain confidence, no doubt,

in the fact that a logical sequence of projected events can be set up along with dates for their anticipated accomplishment. The recent and new civil defense law provides for Federal coordination and guidance, for operation of the Federal Civil Defense Administration, and for prescribed necessary assistance. The Administration rightfully may be expected to suggest organizational structure and staffing patterns; objectives and their priorities; material means and their proper sources of origin; operational programs; training means and measures in technical, administrative, managerial and functional aspects of all programs; uniform standards of measurement of performance; but above all, an integrated, multi-lateral system of controls developed through a consultative participation by physicians. To achieve all of this, patience, tolerance and friendly joint exploration of all of our problems will be essential. In this most difficult phase of all, namely the preparation phase for civil defense, we cannot do without a sense of humor and a penchant for endless work. That work must be contributed by the profession, by the Federal, State and local governments, and by the public.

Physicians have not exhausted existing sources of new knowledge pertaining to civil defense. This is particularly true in technical aspects of modern weapons. There are sufficient references, training courses for key instructors, and training aids available to permit a wider spread of technical knowledge of the modern weapons and their effects, as they might be directed against civilians. Such training of the entire profession need not wait upon additional guides of any nature. In addition, many references are available to permit individual and group study of various possible organizations which would improve our general administrative knowledge and future performance, regardless of the uniform pattern for units ultimately to be proposed in Federal manuals. If the medical leadership does not engage in such studies and does not stimulate and initiate them, but should limit itself entirely to details of a few manuals of the future we

shall have something less than the medical success we have a right to expect. At the same time knowledge is being increased through conferences, study groups and society journals; the advice so necessary to have from the profession to planners for the different governmental agencies will become available.

You might gain confidence in knowing that in the Federal Civil Defense Administration, medical objectives and priorities have been defined and the dates by which we hope to achieve them have been set. It is anticipated that major objectives for the "preparation," "during attack" and "following attack" phases may be defined with reasonable rapidity and transmitted to regional, state and local civil defense offices. They may be furnished also to professional societies, scientific groups, and voluntary agencies; to all Federal agencies with a view to maximum, coordinated utilization of already existing resources; and they may be provided to individuals, families, and groups. At the same time, programs will have been scheduled in a systematic and orderly manner, with priorities, for the provision of material means; for the promulgation of organizational structure, staffing patterns and procedures, measures and activities; for specific training programs; for procedures and methods for measuring the levels of performances; for developing control systems, integrating them with other services of civil defense and for forecasting, promulgating, developing and distributing uniform technical information, guidance and policy. The medical motivation for all of these matters is established and appreciated by the Administrator, Federal Civil Defense Administration.

As a profession we may not be content until equal and better establishment of all of these programs will be initiated by state and metropolitan civil defense organizations, where civil defense ultimately must be made to work. It is your privilege to assure their existence and acceptability. Until all of us do that, we cannot visualize safety for most of our homes, for a

public confidence that we have assured that all hazards of physical, mental and moral origin will be overcome; and that true community health will survive all such hazards.

In signing the Federal Civil Defense Act the President of the United States said, "It (civil defense) will require the best efforts of all of us to get ready . . . to defend our homes. No true American would want to give less than his best to that cause"—It goes without saying that the physician is the bulwark of the Nation in that cause. The physician will accept the drudgeries, the frustrations, the occasional impatience of himself and his brothers because of seemingly unsatisfactory progress in civil defense. He has earned this place by his intimate part in attending the birth, prolonging the life, and delaying that ultimate day of death of every member of the home. He has earned his place because of full knowledge that as the bulwark of the Nation against atomic and all other attacks he will furnish the best medical care any population ever had, so long as his own medical leadership exists in good conscience as "the best efforts of all of us."

The physician may be compelled to do this with insufficient means; with nothing more than he has immediately available wherever a disaster might occur. He will be forced to give only mass attention and treatment to injured thousands, instead of the near ideal treatment of an individual physician-patient relationship all of us eschew so properly. He will be obliged, in the common good and for the sake of National survival, to sort patients in an entirely impersonal manner and without regard to the order in which they came under his medical surveillance. The patients themselves and their families and loved ones, will understand and desire that all of this be done if physicians will have previously informed and educated the public through channels and by techniques already available to us. This will require the most careful and uniform efforts of practicing physicians and health de-

partments, determined and followed by them jointly.

When each physician will have participated wholesomely and cheerfully in a manner somewhat similar to all that we have just considered, then, and perhaps only then, can he realize in

the words of Ruskin, his true goals of preserving the American home:

"This is the true nature of home—it is the place of Peace; the shelter, not only from all injury, but from all terror, doubt, and division."

CORTISONE (CORTONE) IN THE TREATMENT OF ACUTE SUBDELTOID BURSITIS

MARION FRIEDMAN, M.D.

Since the isolation of cortisone and ACTH much effort has been expended in attempting to determine in what diseases or conditions they might be useful. If the manner of action of these materials were known, a more logical approach toward their employment could be undertaken. At this time we can only assume that their action is not on the etiological irritant but on the tissue reactions to that irritant.¹ For this reason, and as a result of numerous clinical empirical trials in a wide variety of conditions, it has become increasingly clear that their greatest therapeutic promise seems to be in acute or self-limiting diseases.²

Acute subdeltoid bursitis is an inflammatory process of the bursa produced by trauma or infection, causing severe pain, tenderness and limitation of motion. Some of the pain and limitation is produced by the associated spasm of muscles surrounding the shoulder girdle. When the disease becomes chronic, further difficulty is caused by the production of villi within the walls of the bursa, with ultimate calcium deposition, and by the development of adhesions.

Treatment, for the most part, has not been entirely satisfactory. Certainly immobilization, local forms of heat (or cold), diets, analgesics, injections of novocaine and operation are not desirable therapy if there is available an oral medication which reduces the period of disa-

bility to a fraction of its previous length. While the use of x-ray therapy has provided much benefit to many sufferers, its drawbacks include cost, length of treatment, period of disability and pain between treatment and effect, and failure to prevent calcium deposition in the bursa.

To date no case reports concerning the use of cortisone or ACTH in the treatment of acute subdeltoid bursitis (or bursitis in any other site) has appeared in the literature. Only two very brief notes have given passing attention to the problem. At the International Congress of Internal Medicine it was reported, "Lately it has been used in toxemia of pregnancy and in subdeltoid bursitis."² There was no further elaboration on this point. In describing the effects of cortisone and ACTH on rheumatoid arthritis Boland states, "non-articular features, such as subcutaneous nodules, enlarged lymph nodes, bursites and tenosynovitis improve or disappear along with improvement in the joints."

The author has recently had the opportunity to administer cortisone orally to three individuals with acute subdeltoid bursitis. It is believed that the results are impressive.

Case 1. G. B., a 46 year old white housewife, was seen on October 14, 1951 because of severe pain and limitation of motion of the right shoulder of three days duration. The pain was so severe that she had not slept for two nights.

This patient had on two occasions between 5 and 10 years ago been hospitalized for a mental illness characterized by depression. About two years ago she had been treated by the writer for a mild depression without hospitalization. History was not otherwise significant.

Examination revealed the right arm being held in forced adduction with spasm of all muscles about the shoulder girdle. Pressure just below the acromion over the deltoid muscle with the arm by the side produced exquisite tenderness. When the arm was abducted to a right angle, pressure over the same area caused no discomfort. Analgesics, immobilization, heat and anti-spasmodics were used for five days without improvement. Her only relief during this time was obtained in brief periods of about two hours after taking codeine sulfate.

The patient was placed on 100 mgm. of cortisone (cortone) orally every 8 hours on the first day, 100 mgm. every 12 hours on the second day and 50 mgm. every 12 hours thereafter until 1 Gm. (forty 25 mgm. tablets) was administered. When cortisone (cortone) was begun all other therapy was discontinued, except that the patient was allowed to use analgesics. She was permitted to move the arm at will. Definite easing of her pain was noted 8 hours after the first 100 mgm. and before taking the second dose. At that time she began moving her arm voluntarily. Within 48 hours all pain, local tenderness and limitation of motion had disappeared and all analgesics were voluntarily discontinued. It was not known how long therapy should have been continued, but the patient was advised to complete the tablets on hand as described above.

She has remained entirely asymptomatic after three months without further treatment. X-rays at that time revealed no evidence of calcareous deposits in or about the bursa. About one week after cessation of cortisone the patient became mildly tense and somewhat depressed but required only mild sedation.

Case 2. M. B., a 32 year old white female, was delivered of twins on November 19, 1951. She had developed a toxemia with rising blood pressure, 2 plus albuminuria, slight ankle edema and rapidly increasing weight. Labor was therefore induced three weeks prior to her expected date of confinement. Twelve days after delivery she developed severe pain, tenderness and limitation of motion in the left shoulder.

Examination two days later revealed findings similar to those noted in Case 1. The patient was placed on cortisone (cortone) orally, using the same regime previously employed. No other therapy was used during

or prior to the administration of cortisone (cortone) except that she was allowed analgesics as desired for the first two days. Again there was notable relief in 8 hours and complete remission of the process in 48 hours. During therapy the patient gained 5 pounds and developed mild ankle edema. Her urine and blood pressure remained normal. With cessation of therapy the edema subsided.

There has been no recurrence of symptoms. X-ray examination two months later revealed no calcification in or about the bursa.

Case 3. H. T., a 42 year old white housewife, was seen on January 28, 1952 because of severe pain in the left shoulder with associated limitation of motion of two days duration. She had been unable to sleep the night before because of pain.

Examination revealed findings about the shoulder similar to those previously noted. She was placed on cortisone (cortone) orally using the same regime already described except that no analgesics were administered concurrently. Within eight hours there was noticeable diminution of pain. After 36 hours she was able to voluntarily raise her arm over her head although it produced some moderate degree of pain. After three days she was well except for mild pain in the shoulder on motion and mild tenderness to pressure over the bursa. These residual symptoms were still present when she had used the last tablet (a total of 40) but had disappeared two days later, or nine days after therapy was begun.

COMMENT

The rapid involution of the acute bursitis in two cases treated with cortisone (cortone) and the somewhat less rapid recovery of a third, while not unequivocal evidence of its value in all such cases, would suggest that further studies along these lines are indicated. It is quite possible that one-half to three-quarters the dosage used here would have been equally efficacious in the first two cases. In the two cases which responded rapidly, analgesics were also used for the first 48 hours. In the third, where involution was somewhat slower, analgesics were not employed. Whether or not this was coincidental would seem to justify further study.

It is also probable that cortisone (cortone) prevents deposition of calcium in the bursa and adhesions about it. The rapid involution of the process under cortisone (cortone) therapy would seem to be responsible for this phenomenon.

The appearance of mild adverse side-effects in the first two cases is of interest in that it has become well recognized that cortisone (cortone) and ACTH tend to produce these in many persons who previously sustained mental illness and kidney alteration. Nevertheless, the period of therapy appears so brief that these conditions are not regarded as sufficient contraindications for most persons.

SUMMARY

1. The use of cortisone (cortone) in the treatment of three cases of acute subdeltoid bursitis is described.

2. The possibility that this mode of therapy prevents calcific deposition in the bursa and adhesions about it is suggested.

3. These cases are presented to stimulate further study along similar lines.

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THIRTY YEARS OF PHYTOPHARMACOLOGY OR APPLICATIONS OF PLANT PHYSIOLOGY TO MEDICAL PROBLEMS¹

DAVID I. MACHT, M.D., F.A.C.P.

This is a survey of thirty years' research work already published and an announcement of several new investigations in progress in a new field of biology. Thirty years ago the author who was then associated with the late professor John J. Abel at the Medical School of the Johns Hopkins University conceived an idea to compare the pharmacological action of drugs and poisons on animal tissues and protoplasm with the action of the same chemicals on vegetable tissues and protoplasm.

Pharmacology taught in medical schools usually deals with the effects of drugs on animals and is strictly speaking Zoopharmacology, and as Physiology medical men usually understand Zoophysiology or the effects of drugs on animals. There is a most important field of biology known as plant physiology or Phytophysiology. The

author has attempted to develop a field of Zoopharmacology, and he has spent considerable time in the laboratories of the late Burton Livingston the eminent professor of plant physiology at Johns Hopkins.

Many methods may be employed for studying the effects of drugs or chemicals on plants. Among them may be enumerated the following: germination of seeds, growth of roots and stems, growth of yeasts and molds, oxidation-respiration phenomena, respiration, transpiration, metabolism in general, vernalization, photosynthesis, etc. A most convenient and practicable method employed by the author is the measurement of root growth of seedlings of *lupinus albus* in hydroponic solutions under exact ecological conditions of light, temperature, etc. In this way many pharmacological studies have been made and published on all kinds of chemicals and drugs such as: organic and inorganic mercury compounds, series of alcohols, chemical isomers

¹ Department of Pharmacology Research Laboratories, Sinai Hospital, Baltimore. Read before Section G of AAAS, December 29, 1951, Philadelphia, Pa.

of menthol, amino acids, cardiac glycosides, snake-venoms, sulfa drugs, etc. The most important findings, however, from a medical point of view have been in experiments with different blood sera and other body fluids. Inasmuch as it was discovered that chemicals as drugs derived from the animal world were usually and relatively more toxic for plants than for animals, it was thought worthwhile to employ a phytopharmacological approach to the detection of substances in the blood which have hitherto not been demonstrable by animal experiments and even by ordinary chemical tests.

By accurate quantitative experimental methods the author has demonstrated the presence of a toxic substance—menotoxin—in the blood serum, sweat, saliva, milk and other secretions of menstruating women. By similar methods, it was established that in pernicious anemia and not in any other kind of anemia or leukemia there is another toxic substance in the blood which is different from menotoxin. Further experimentation revealed characteristic toxic reactions on *lupinus seedlings* by the blood sera of *trachoma* and *leprosy*. A very extensive research on a highly fatal skin disease *pemphigus* has been conducted by the writer and the late dermatologist Isaac Pels. It was found that this particular skin disease and no other with the exception of leprosy gave a characteristic phytotoxic effect which is now extensively employed by the writer for the diagnosis of pemphigus and for the evaluation of various methods of its treatment. It was further found that the toxin of pemphigus can be destroyed or antagonized by irradiating specimens of the serum with certain X-rays, and later it was found that ACTH and cortisone in minute quantities also neutralize the pemphigus toxin in vitro. These same findings have been confirmed clinically. More recently the author has been engaged in the study of the blood in individuals suffering from psoriasis. It was discovered that psoriasis like most other dermatoses did not inhibit the growth of the lupinus seedlings, but by the employment of specially

treated plants it was found that psoriasis gives a specific phytotoxic reaction which is both of scientific and practical diagnostic interest.

Perhaps the most important contribution of phytopharmacology with the exception of the work on pemphigus has been the result of a twelve year investigation by the writer and his collaborators on the blood of mental patients. This research in which approximately 1400 specimens of blood serum from different hospitals have been examined led to the following conclusions:—All true psychoses whether so-called “organic” or “functional” exert a definite phytotoxic action on the root growth of lupinus albus seedlings reared under normal laboratory conditions. The degree of toxicity varies quantitatively not so much with the type of psychosis—whether melancholia, mania, depression, schizophrenia, paresis etc.—but with the degree of the severity of the disease. Similar phytotoxic reactions are exhibited by the spinal fluids of psychotic patients. This phytotoxic reaction is valuable in diagnosis of doubtful cases of psychoses. It also offers a criteria for the evaluation of therapeutic measures, and obviously may be of medical legal interest. Strangely enough bacterial infections give no phytotoxic reactions. On the other hand, lupinus seedlings can readily detect carbon monoxide in the blood and actually demonstrate the effects of stray x-ray waves in the blood of radiologists and their staffs.

In addition to the work on psychoses and pemphigus which is still continuing, the author is now engaged in investigating two other important pathological conditions by a phytopharmacological approach. While most bacterial infections and viral diseases yield no phytotoxic effects as compared with normal human blood serum, it was thought worth while to inquire into the influence of syphilitic blood on special plants. Syphilitic blood serum and spinal fluid do not produce any inhibition in the root growth of normal seedlings of lupinus albus and in fact, are usually even less phytotoxic than normal serum. When, however, the same sera or spinal

fluids are tested on so-called *vernalized* or *yarozized* seedlings after subjecting to low but not death-dealing temperatures, or by exposure to suitable dosages of filtered x-rays, a very characteristic phytotoxic reaction is observed with syphilitic sera. This phytotoxicity is quantitative in nature, and runs parallel to the Wasserman or other serological tests. It is very useful in evaluating the anti-luetic efficacy of various antibiotics.

Another major research engaging the author's attention is a phytopharmacological examination of the blood in tumor patients. Several lines of approach have been tried and new ones are planned. Some very encouraging findings have been made. It can be provisionally stated that sera from cancer patients have so far been found to exhibit characteristic phytotoxic effects when studied on vernalized seedlings. Another peculiar property of cancerous blood sera in contrast to normal sera has been noted in connection with quantitative studies on the phenomena of photosynthesis taking place in certain aquatic plants.

It is hoped that these novel approaches may contribute a bit to the sum total of our knowledge concerning this vital subject.

The author's methods for studying blood sera have been employed, especially in connection with studies on menstrual toxin, and psychotic blood sera by German, Russian, French and Italian investigators. In the U. S. these methods have engaged the especial attention of agricultural chemists. A detailed monograph by the author on Phytopharmacology with numerous references to literature is in preparation.

Thus with the development of this new department of biology some rather significant contributions have been made to our sum of knowledge. The above studies in phytopharmacology are a good illustration of the valuable results which may accrue through the collaboration of medical research men not only with the purely clinical laboratories, but also with the departments of the fundamental sciences, chemistry-physics, zoology, botany.

SYMPOSIUM ON THE DOCTOR IN COURT¹

INTRODUCTION

WALTER D. WISE, M.D., *Moderator*²

The meeting seems to be in order without being called to order.

Judge Smith, Members of the Panel, and Members of the State and City Bar Associations, and of the State and City Medical Associations:

No matter how high the standards of procedure in any endeavor have been developed and maintained, there are no doubt opportunities for improvement. The

problems that are to be considered in the symposium tonight encompass the range from the fundamentals—honesty, integrity and knowledge—to technicalities and techniques.

Many subjects will be discussed at this meeting. Some may be settled. Others will not be. It is hoped that much will result to aid lawyers and doctors, not only in Court, but in the State Industrial Accident Commission and also the Medical Board of the State Industrial Accident Commission.

It is well known that the scales in the hands of justice in this state are well balanced, but all equipment needs oiling and adjusting from time to time. And these are our functions tonight.

At the proper time, written questions from the floor

¹ Arranged by the Joint Committee on Medicolegal Problems of the Baltimore City Bar Association and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee.

² President of the Medical and Chirurgical Faculty of Maryland, 1951.

may be sent in, or you may arise and direct your question to the panel; and if there is sufficient time, we hope to be able to have some general discussion.

The speakers are asked to limit their papers to twenty minutes; and if we have time available for discussion, we will ask those who make remarks to limit themselves to three minutes.

The first paper this evening is to be on the subject of Medical Expert Testimony from the viewpoint of Trial Counsel, by Mr. Robert E. Coughlan, Jr.

Mr. Coughlan was graduated from St. John's College, with a Bachelor of Arts Degree, graduated from the University of Maryland, with a Bachelor of Law Degree, and for over twenty years he has been actively engaged in the trial of Workmen's Compensation cases and many cases in Court.

The best recommendation of Mr. Coughlan is that he was chosen by his peers to present this subject of Expert Testimony from the Viewpoint of Trial Counsel.

It gives me great pleasure to introduce Mr. Coughlan.

EXPERT TESTIMONY FROM THE VIEWPOINT OF TRIAL COUNSEL

ROBERT E. COUGHLAN, JR., ESQUIRE³

The subject which I have been asked to speak on, as far as the angle of the Bar is concerned, is going to be dealt with mainly from the standpoint of damage suits and Workmen's Compensation cases.

For the purpose of clarity, this topic has been divided into three phases:

1. From the standpoint of the Plaintiff.
2. From the standpoint of the Defendant.
3. From what could be considered the ideal standpoint.

The doctor's testimony in a suit for damages is the heart of the case. While it is true that there must first be liability before the Defendant can be required to respond in damages, the doctor is still the most important witness. When a doctor testifies on behalf of the Plaintiff, he should endeavor to testify not in accordance with his feelings, but in accordance with his findings. The Plaintiff's attorney, in seeking a doctor to examine his client so he may be apprised of the extent of the injuries, many times will try to obtain the services of not the best doctor from a medical standpoint, but the doctor who will make the best witness. The Plaintiff's attorney often times regards his duty to his client to obtain the largest verdict possible. He is not interested in

what his case is worth, but how much he can get. He, therefore, seeks a doctor who will be possessed of knowledge, but whose conscience does not bother him. Such a doctor will testify not in accordance with his findings, but in accordance with what he believes he can get away with.

The two most serious types of injuries are back injuries, which the late Judge Roland Adams referred to, particularly in reference to sacroiliac injuries, as "The Courthouse Joint," and head injuries. When a patient complains of pain in his back, many doctors will find no objective symptoms, but nevertheless will accept the word of the Plaintiff and base their findings of the disability accordingly. In fact, some doctors have gone so far as to state that when a patient moves his legs or his back and complains of pain, that the movement of the back or leg and the complaint of pain constitute an objective sign.

In head injuries, which are now rapidly becoming the most popular injuries, less conscientious doctors will testify that the patient is suffering from a post-concussional syndrome, that he should avoid heavy work, fatigue, climbing to high places, exposure to extreme heat or cold. When asked if, in his opinion, he thinks the complaint of pain is justified, the standard answer is "I believe so, and it is not unusual for these symptoms to persist as long as a year and

³ Member of the Bar Association of Baltimore City and the Maryland State Bar Association.

many times they become permanent." The doctor will then continue and state that in view of the fact that the patient did not have any complaints of pain in his head prior to the injury and complains of pain since the injury, he must necessarily attribute the pain to the injury.

In recent years, the operation for ruptured intervertebral disc has opened a new field as far as doctors are concerned. If the x-rays show any narrowing of the intervertebral spaces or even in many instances, where they do not, the less conscientious doctor will interpret the x-rays, though not an expert in that field, as tending to show a narrowing of the spaces and will state the possibility of a ruptured disc.

In head injuries, electro-encephalograms are made and interpreted by the less conscientious doctor to indicate a disturbance of the brain. While not in a position to discuss the interpretation of either x-rays or electro-encephalograms, experience has shown, over a period of years, that in cases in which the doctor had testified that the patient had a possible rupture of an intervertebral disc, or a disturbance of the brain, that after the case was settled, the complaints disappear.

A real danger exists when medical testimony of this kind is given. Juries, like the public in general, sympathize with the underdog, the injured person, and reason, particularly if there is liability on the part of the Defendant, that the injured person did not have such complaints before the accident; that as he has ostensibly a reputable doctor testifying on his behalf, conclude that the person must have those complaints or injuries. They further reason that the doctor, who testified for the Defendant is employed by the Defendant for the purpose of discounting the claims of the Plaintiff and therefore, are not in many instances, impressed with such testimony, even though it is given by excellent medical men. Such testimony creates a hazard which Defendants and insurance companies should not be exposed to. Insurance companies and self-insurers expect accidents and expect to

have to pay for them. For the most part, at the present time, they expect to pay reasonable amounts and are willing to do so. They do not expect to have to pay exorbitant verdicts where the injuries are not justified. The Bar attempts to police its members and keep them in line. Something should be done by the doctors to try to accomplish the same purpose.

Discussing this from the standpoint of the Defendant, the doctor for the Defendant should likewise be perfectly honest in his testimony. He should not underestimate the claim and he should not underestimate the percentage of disability. Unfortunately, in some instances, this is done. The reason for it, which is not a good one or a sound one, is that doctors who have had a great deal of experience in damage suit cases, knowing that the Plaintiff's doctor will exaggerate, have a tendency to minimize the claims and underestimate the percentage of disability. This kind of testimony is almost as bad as that of the unscrupulous doctor for the Plaintiff.

A law suit should not be a battle of wits. It should be an honest determination on the part of the litigants on both sides to present their case fairly and honestly in order that a Jury may determine the issue. There are many cases in which perfectly honest lay witnesses will view the accident and testify almost in direct opposition to each other. This can be explained and accounted for in many instances on account of the fact that no two people will see the accident from precisely the same angle. It is perfectly possible and reasonable to expect honest differences of opinion as far as the medical profession is concerned. When, however, one doctor will testify that the man has a 50% loss of use of his back and a doctor for the opposing side will say that he does not have any disability or perhaps a 5% disability, then something is wrong. One of the doctors is badly mistaken or deliberately not telling the truth.

When the new rules of Practice and Procedure were adopted, the element of surprise, to a considerable degree, was taken out of a case. The

names of witnesses can be obtained and their testimony taken so that each side will know, to a degree at least, what their testimony will be. This goes a long way toward solving the question of liability. When, however, the testimony of the various doctors is taken, many times their opinions are so completely at variance, that it is utterly impossible to reconcile the difference. If the doctors are honest in their divergent views, then the lawyers, if honest, for the respective parties could accomplish a great deal if they approach the problem by getting one or two totally disinterested doctors to examine the Plaintiff and give a report. This would be a long step toward correcting the abuses that exist at the present time.

Most any member of the Bar who has been actively engaged in the trial of damage suits can cite, from his own experience, numerous instances of false and incorrect medical testimony. To refer to one such case, while appearing for the Plaintiff, the question was whether the Plaintiff, who had developed epilepsy as a result of the accident, was permanently totally disabled. The case was investigated from a medical standpoint and it was learned that the initial injury was a fractured skull with displacement of the fragments. The immediate problem for the attending physician, who first saw and treated the Plaintiff, was whether to operate and take a chance on adhesions or not to operate and take a chance on what might happen. The doctor decided not to operate. When epilepsy developed, the insurance company produced this doctor who testified that an operation would relieve the present condition and the man would be all right. Doctors who had examined the Plaintiff on his own behalf were of the opinion that an operation was dangerous and that things had better remain as they were. The doctor who saw the man originally and treated him as a result of the accident testified that an operation would cure him, even though some two years had elapsed since the initial injury. Furthermore, after explaining what was necessarily involved,

when pressed on cross-examination as to the dangers involved in such an operation, he testified that it was as simple as a tonsilectomy. This testimony was obviously not honest, but an attempt to cover up.

It is urged that the doctors themselves do something about those members of their profession who give basically false and untrue testimony. It is further urged that steps be taken, if not to discipline, to educate the doctors so that they will not give misleading testimony. The difficulty lies with the doctors. The men of high standing are tremendously busy and take the position that it is their duty to treat the sick and not become professional witnesses. They are horrified when classic examples of distorted testimony are brought to their attention, but they become squeamish about taking any steps to correct it. They do not wish to become involved in such unpleasant matters. It is a breach of professional etiquette to testify against another doctor or in any way take him to task. Thus the unscrupulous doctor continues to give false testimony, Juries are misled, Defendants pay much more than they should and the evil continues.

Steps can be taken by the doctors that would be corrective and salutary. Doctors, when asked to appear in Court, complain about the loss of time in waiting before they testify. To a very great extent, this has been eliminated and can be improved even further if counsel are competent and the Judges cooperate. Sometimes, however, a doctor is asked to be present to hear the opposing doctor testify and in order to keep him in line by his very presence in the court. This should not be necessary and if the unscrupulous doctor knew that his testimony would be reviewed by a board of competent doctors and that he would be disciplined or educated, as the case may be, the evil to a great extent could be corrected.

If the doctors could agree on a method to evaluate disability and if the doctors would cooperate with the Bar, and the top flight men in their profession would give a portion of their

time to examine and testify in cases in which there is an honest divergence of opinion, great headway would be made toward correcting the present conditions.

A doctor should not be an advocate for the side that he represents, so to speak, nor should he be fearful because of unfair cross-examination. The Judges in the respective courts, for the most part, will see that the doctor is not harshly treated.

Some doctors, who are familiar, to a certain degree, with the rules of evidence, will blurt out a statement which they know from their experience in testifying is not admissible, but do so for the sole purpose of assisting their side of the case. A conscientious doctor will not adopt such tactics nor will he be a party to any scheme concocted by the attorney to bring out evidence that is not admissible. While it is true technically such evidence is stricken from the record by the Judge, the Jury has heard it and many times is influenced by such statements, arguing among themselves that while such statements are legally inadmissible, they are, none-the-less, true and should therefore be given consideration.

A word should be said with regard to claims under the jurisdiction of the Workmen's Compensation Act. Fortunately, a considerable number of highly competent doctors are specializing in this field. The members of the State Industrial Accident Commission usually, in the course of time, become acquainted with the doctors who appear before them and are able to determine the ones that they can rely on. In a case where a doctor for the Claimant estimates the disability to a man's back at 75% and the employer and insurer's doctor estimates the disability at 5%, the Commissioner ordinarily will ask the attorney for the employer and insurer if he will agree to the Commissioner sending the man to another doctor and if he will pay the bill. In the vast majority of cases, the attorney for the employer and insurer will readily agree to this and if a competent man is selected by the Commissioner, a fair award will ordinarily be passed.

Therefore, in the cases before the State Industrial Accident Commission, there is a greater chance for a fair award but unfortunately, however, what usually happens is that, if the Claimant does not get what his attorney thinks he *can* get him, the Claimant's attorney takes an appeal. When the case is tried before a Jury, the Defendant's attorney is faced with the same situation as he is faced with in a damage suit. For this reason, strenuous efforts should be made by the doctors to keep the medical testimony before the State Industrial Accident Commission within bounds, and the doctors appearing before the Commission should be made to realize that their testimony will be just as carefully scrutinized as if it were given in the law courts.

Cooperation between the doctors and joint examinations under the supervision of a third non-partisan doctor would be a tremendous step forward in the direction of stamping out the practice which now exists. Not so long ago, one of the most reputable orthopaedic surgeons examined an injured man and reached the conclusion that he had a large percentage of permanent disability. The insurer's doctor was very much of the opposite opinion. Another doctor was selected by the insurer and an examination was made of the man and this third doctor agreed wholeheartedly with the doctor for the insurer. This third doctor, so to speak, unknown to the attorneys in the case, arranged for an examination between the orthopaedic surgeon who had seen the man at the request of his lawyer, the insurer's doctor and himself. This doctor was able to convince and to demonstrate to the Claimant's doctor, so called, that he had been misled and fooled by the Claimant so that he completely revised his previous opinion and the result was a settlement of the case for a very small percentage of the disability. This illustrates what can be done if the doctors cooperate.

In giving testimony, the doctor should be careful to discuss the injuries in such a way that a Jury can understand him and not stick to technical terms. Many times a Jury becomes

utterly lost in the terms used and when they discuss the case in the Jury Room, they are hopelessly confused.

A rather classical illustration was a little case in which the lawyer for one side said, "Doctor, in language as nearly popular as the subject will permit, will you please tell the Jury what the cause of this man's death was?" And the Doctor said, "Do you mean the proximate *causus mortis*?" The lawyer said, "I don't know, I will have to leave that to you." And the doctor said, "Well, in plain language, he died of an oedema of the brain that followed a cerebral thrombosis or possibly embolism that followed, in turn, an arteriosclerosis combined with the effect of a gangrenous cholecystitis." And a Juror said, "Well, I'll be damned." The Court said, "Ordinarily, I would fine a Juror for saying anything like that in court, but I cannot in this instance impose a penalty upon you, sir, because the Court was thinking exactly the same thing."

As far as the Bar is concerned, the Bar can help themselves a lot with their questions, as may be shown by this illustration: A lawyer said to the witness, "Now, sir, did you or did you not, on the day in question, or at any time previously or subsequently, say or even intimate to the defendant or anyone else, whether friend

or mere acquaintance, or in fact a stranger, that the statement imputed to you, whether just or unjust, and denied by the plaintiff, was a matter of no moment or otherwise? Answer, did you or did you not?"

"Did I or did I not what?" asked the witness weakly.

DR. WISE: Well, that was quite a castigation of the medical profession, I think.

And I hope sometime we will have on this program the doctor's idea of the way lawyers conduct their cases in court.

The next paper is by Dr. Conrad Wolff, Expert Testimony from the Viewpoint of Industrial Medicine.

Dr. Wolff is a graduate of McGill University of Montreal in 1917, and a Veteran of World War I. He came to Maryland in 1927, and has made quite a place for himself here in that time.

He has been affiliated with the Johns Hopkins Hospital, the Union Memorial Hospital and Mercy Hospital.

He is a member of the Medical Board of the State Industrial Accident Commission, and he is Associate Professor of Medicine at the University of Maryland Medical School.

The Courts have had centuries of time to develop their procedures. This Commission has had but a few years. It is well known that they have done excellent work and deserve a great deal of credit and thanks from the public, from the medical profession, and all citizens.

It gives me great pleasure to introduce Dr. Wolff.

EXPERT TESTIMONY FROM THE VIEWPOINT OF INDUSTRIAL MEDICINE

THOMAS CONRAD WOLFF, M.D.⁴

The Medical Board of the State Industrial Accident Commission was started some years ago as an advisory board to the State Industrial Accident Commission in matters of disease as distinct from traumatic injury.

Consequently the Medical Board deals in occupational diseases such as silicosis, silico tuberculosis, dermatitis, a large variety of diseases

resulting from contact with industrial fumes, and an infinite variety of other conditions that come largely under the head of internal medicine.

"Expert Evidence" by competent authority in Industrial Medicine, a division of Internal Medicine, should be utilized wherever there exists litigation about Industrial disease as distinct from Industrial injury.

Litigation commonly takes place in the form of hearings before Judge and Jury or before duly

⁴ Associate Professor of Medicine, University of Maryland School of Medicine.

appointed Commissions or Boards of Inquiry. Lawyers representing respective sides of a dispute hire their expert evidence and these experts are expected to speak for their side.

Such is the current system. Nobody regards it as ideal but there is no widespread movement to correct it.

For clarity, it will be necessary to define certain terms. Do any of you know a definition of "Expert Evidence" as it applies to medicine? The average lawyer will probably tell you that it means "Evidence on a medical subject by a Doctor of Medicine." Such a definition, so all-inclusive, becomes an absurdity when one realizes the infinite complexity of Modern Medicine. No single Doctor of Medicine could become familiar with all branches of medicine to a degree where his testimony could be rated as universally expert. Yet it is not uncommon practice for lawyers to seek as "Expert Evidence" physicians who have insufficient familiarity with the subjects at issue. The reasoning appears to be, "He is a Doctor of Medicine. He knows something about the subject. We can use him."

I have no wish to reopen old cases nor to indulge in personalities. I shall, therefore, submit to you two cases as examples. However, I shall make a few fictitious changes in some of the details, preserving enough of the essentials so that the cases may serve as valid examples.

A widow appears in court to claim damages because her husband may have died from an occupational lung disease. Her Attorney has brought to the hearing a "Doctor of Medicine as Expert Testimony." This doctor seems to have had something of a migratory career. Currently, he is doing a general practice. At one time he was an interne on the staff of a rather obscure institution for the treatment of diseases of the chest—but that was many years ago. The hearing is held before a Medical Board for Occupational Disease composed of doctors who owe their appointments to approval by their State Medical Society, and not to any political considerations.

These doctors cross question the "Expert Witness" and learn almost at once that his knowledge is fundamentally lacking. He reasons falsely from ignorance of basic science. His conclusions are untenable. However, he is glib and has picked up enough pseudo-professional jargon so that in the hands of a sharp lawyer he could probably impress a jury. However, he is heard by physicians, not by jurymen, and the value of his testimony is zero.

Why has the attorney brought such a man to the witness stand as his Expert Evidence? Why has such a doctor connived at being rated as Expert Evidence in a matter in which his knowledge was so palpably deficient?

Before citing my second case, I must remind you that in the profession of medicine, highly qualified men from internationally famous institutions of research constantly reexamine our stocks of professional information—text books and such. The results of their labors often oblige us to revise opinions held in respect for years. Many text books contain items of information which current research has rendered untenable. Bear this in mind as I cite my second case.

A skilled laborer who had spent his working life in contact with various metals died during one of the terminal events of arteriosclerotic cardiovascular disease. His widow remarked to her attorney that her husband's life had been healthy until recently except for an attack of lead poisoning many years previously. The attorney then told her in effect that lead poisoning causes arteriosclerosis. He reminded her that her husband had worked for the same firm for 40 years; that he had developed lead poisoning while in the employ of this firm; that the firm was, therefore, liable for her husband's death on the grounds of occupational disease.

A hearing is held before the Occupational Disease Board. The members of this board are aware that according to the recent findings of a research organization of high international repute, any connection between the disease of arteriosclerosis and lead poisoning is purely coin-

cidental. The decision of the board absolves the insurer from responsibility in the death of the man.

A member of the State Accident Commission, a lawyer, reverses the decision of the Medical Board.

The board announces its reversal to the director of the above mentioned research organization who in turn agrees to attend a re-hearing of the case as the Board's Expert Testimony. He spends considerable time in outlining the processes whereby the research organization had arrived at its conclusions in respect to the coincidental character of lead poisoning and arteriosclerosis. He submits to cross questioning by opposing counsel.

As rebuttal the attorney for the widow introduces his Expert Testimony. This is a doctor of medicine who admits that his specialty is far removed from the subject of industrial poisons and their effects. He denies that he has ever treated any cases of industrial poisoning. It seems that he has had no particular interest in the subject until employed by the attorney as Expert Evidence. He states that the texts he has read on the subject favor the hypothesis that lead poisoning produces arteriosclerosis.

The case ultimately proceeds to a higher authority, where the outdated opinion of the text books is upheld and so now, for all time, scientific research of the highest type to the contrary notwithstanding, the law asserts that lead poisoning produces arteriosclerosis—and all is embalmed and hallowed in legal precedent. It does not require an abnormal imagination to visualize the gainful opportunities for old men who at one time suffered from lead poisoning, not to mention the financial emoluments accruing to the type of lawyer and doctor who would prod them into litigation.

Do the gentlemen of the legal and medical profession in the State of Maryland approve such techniques of their brother professionals? If they disapprove, is there any present machinery whereby they may visit their disapproval

upon those who incur it? If there is no present machinery, can some be devised?

Inasmuch as I know of no generally accepted definition of Expert Medical Witness, I am emboldened to hazard one of my own.

An Expert Medical Witness may be defined as a "doctor of medicine who restricts his testimony to subject matter wherein he has become familiar through years of interest as manifested by study, research or practice; that his competence in such subject matter is known to his colleagues; and that his reputation for integrity has not been called into question."

I should like to see the governing body of our medical society issue at specified time intervals a panel of such Expert Medical Witnesses, properly classified as to their fields of knowledge. These witnesses' periods of availability should be short and some provision should be made to defend them against repeated demands on their time. However, these witnesses should meet reasonable demands as a matter of civic responsibility.

Such a panel of Expert Medical Witnesses should be available to the law society.

And now with great hesitancy, I should like to ask few important questions.

1. Is it possible in a difficult and complicated medical litigation, that the presiding officer of the Court, Commission or Board of Inquiry have the power to draw from the panel issued by the medical society the names of whatever Expert Witnesses may seem to him to be necessary? Or alternatively could the medical society make these nominations at his request?

2. Would it be possible that these Expert Witnesses be furnished with case histories, laboratory reports and stenographic transcripts of the legal procedures that have already taken place?

3. Would it be possible to accord these Expert Witnesses reasonably adequate time in which to review the medical evidence and reach reasonable conclusions?

4. Would it be possible to arrange for the pro-

tection of these witnesses against the importunities of Counsel, or other interested persons while reviewing the evidence, though subject to cross questioning in court after they had reached their conclusions?

5. Would it be possible to arrange that the emoluments of these Expert Witnesses be added to the costs of court and defrayed ultimately according to the direction of the presiding officer of the Court?

6. Would not such a system as this do away with the undesirable situation where each side to the dispute has its own "Expert Witness"?

I should like very much to see these matters discussed, because, as I view it, constructive changes in some present techniques may very well be indicated.

SUMMARY

A. A suggestion is made that a definition of EXPERT MEDICAL WITNESS be reached by consultation and agreement between our legal and medical societies.

B. Testimony of such EXPERT MEDICAL WITNESSES as so defined will be the only type admitted as EXPERT EVIDENCE before courts, commissions and boards of special inquiry. Infraction or attempted infraction of this stipulation by lawyers or doctors should incur the displeasure and appropriate disciplinary action of the law and medical societies.

C. That a properly classified panel of such EXPERT MEDICAL WITNESSES be nominated by the medical society for short periods of service, to be replaced by another such panel when the period of service has expired, and that the doctors on such panels reply to calls for such service as a matter of civic obligation.

D. That such EXPERT MEDICAL WITNESSES be selected as seems necessary by the presiding officers of courts, commissions and boards of inquiry, and that these WITNESSES serve as representatives of courts, etc.

E. That the present practice wherein each side to a litigation hires and pays its so-called

EXPERT MEDICAL WITNESS be discontinued.

F. That emoluments accruing to EXPERT MEDICAL WITNESSES be added to the "Costs of the Court" and defrayed through Court Order, the EXPERT MEDICAL WITNESS has therefore no conceivable personal or prejudiced interest in the outcome of the dispute.

DR. WISE: We have five speakers, and have only heard two of them. I think if the meeting were called off now, it would have been well worth while. I can foresee that good is going to come out of this meeting.

The next speaker is also a Canadian who has endeared himself to Baltimore.

His subject is Expert Testimony from the Viewpoint of Traumatic Surgery. The speaker is Dr. George Eaton, who was born in Nova Scotia. He is a graduate of McGill University, like Dr. Wolff. He is Assistant Professor of Orthopedics at Johns Hopkins University School of Medicine; Assistant Medical Director at Children's Hospital School, and Visiting Orthopedic Surgeon at Union Memorial Hospital, Church Home and Hospital, Women's Hospital of Maryland and Bon Secours Hospital.

He is a member of the American Academy of Orthopedic Surgeons, American Orthopedic Association, and several other professional and other organizations.

I would like to digress for a moment to just recount a little personal experience, if I may be allowed that privilege.

Dr. Eaton served in World War II, rapidly became recognized in the Pacific, and was made a Consulting Orthopedic Surgeon, which was a high ranking position. He came back to Baltimore, and unfortunately got here just about the time of the Battle of the Bulge. We had to reactivate East Coast Hospitals that had been practically closed. Patients were being flown in here at a terrific rate. One hospital, which was very unattractively located, had 1500 orthopaedic cases, consisting in a large percentage of compound fractures of the femur and the humerus. They had one well trained orthopaedic surgeon, and several less well trained. The chief orthopaedist could not make the rounds of 1500 patients in a week. He could not see all of his patients and do his other work. Dr. Eaton was asked if he would step down from his high position of Consulting Surgeon and take a plain orthopaedic surgeon's job in that hospital and divide the service with the other orthopaedist. He graciously did it. That is the kind of person he is.

It gives me great pleasure to introduce Dr. Eaton.

EXPERT TESTIMONY FROM THE VIEWPOINT OF TRAUMATIC SURGERY

GEORGE O. EATON, M.D.⁵

My remarks are perhaps not going to be too condemnatory, but perhaps they will stir a little bit of comment or questions.

In the interests of justice, anyone can be compelled to attend court to testify to facts within his knowledge. A doctor may be issued a subpoena to testify as to facts, and he may be adjudged in contempt of court should he refuse to obey the summons. Such a witness is classified as a statutory witness in contrast to the expert witness.

Expert testimony consists of delivering opinions which are based on a specialist's knowledge and experience and which the court needs in order to understand properly the merits of the case. Workmen's Compensation laws and the constantly enlarging field of insurance are especially productive of the need of expert medical testimony, particularly concerning traumatic cases. We are morally obligated to attend court and testify for the patient whom we have treated for injuries on which the court action is based. Our services can also be solicited by the plaintiffs or their counsel for the purpose of examining a patient, rendering a written opinion, and being prepared to testify during the trial.

A very large proportion of the members of the medical profession avoid, if possible, giving expert testimony, one reason being that it entails a cross-examination which sometimes seems to question the honesty of the witness and subjects him to the insinuation and sarcasm of the opposing counsel. The doctor should keep in mind that he has the superior knowledge and that his is the role of an instructor in the court.

The sole aim of the medical witness should be directed toward maintaining a clear issue and to expedite in every practical way the ends of justice. That function should rule out all bias

and tendency to partisanship. The task of freeing medical testimony from all improper factors and influences is ours. If, on the witness stand, a doctor violates the standards of his profession, some other doctor is sure to know of it. On the latter rests the initial responsibility, for activating the professional attention deserved by the misconduct.

In court and on the witness stand, you will have the feeling that the lawyer on your side is your friend and that the lawyer on the opposing side is not. Actually, this idea is not justified. Most opposing lawyers are equally interested in a good performance on your part and will tend to admire a modest and courteous attitude.

In answering questions, tend to address the jury and the judge rather than only the interrogating lawyer. Keep your voice up and speak clearly, that you may be understood and that the court stenographer may record what you say. It is considered most important to tell the truth, the whole truth and nothing but the truth. It is a mistake to volunteer information thinking that it will help the case alone. Do not attempt to help the counsel on either side. Answer as briefly as is reasonable the questions which are propounded. Try to be attentive to all questions. Try not to give the impression that you know it all. Above all, be very frank. If the lawyer propounds a question, the answer to which you do not know, do not hesitate to state that you do not know the answer. The court recognizes that no witness is completely informed on all subjects, and such a response to a question is not considered detrimental. If the opposing counsel appears to be deliberately irritating, it is most important not to lose your temper and to take your time so that you will not contradict previous testimony.

The question of remuneration for expert testimony might be briefly discussed. Famous opin-

⁵ Assistant Professor of Orthopaedic Surgery, The Johns Hopkins University School of Medicine.

ions have been handed down that a doctor's special knowledge is his property and that a court may not take his property from him without remuneration. In the case of a statutory witness, a nominal witness fee is paid to compensate him for his loss of time from work. In the case of the expert witness, the doctor should charge for his time in court. A useful procedure is to inform the lawyer in writing, before you examine a patient that you demand that the lawyer assume responsibility for payment of charges for examination, x-rays if taken, and rendering a written opinion. In addition, if the case comes to court, you should, before trial, obtain a guarantee from the lawyer that your fee for testifying in court will be paid. As a matter of fact, doctors have been subpoenaed, and have been compelled to attend court, to give expert testimony without remuneration being arranged. This is the exception rather than the rule, and as a procedure will not bear close legal scrutiny.

It is important to remember during the examination of the patient for the purpose of legal procedures not to prescribe for the patient, or even give opinions to the patient as to his diagnosis, treatment, or prognosis. This is the province of the doctor who is treating the patient.

The expert witness should take to court with him the report of his examination of the claimant. He should expect to read that report to the court and interpret medical terms as he goes along. It is most important to remember that neither the judge nor the jury understand what a trochanter is or what a diastasis is. If you use such terms in court, it will be resented by the court since it exposes their medical ignorance. As you talk, think ahead and substitute lay terms insofar as possible for medical terms.

Appraisal of injuries and their immediate and future disability-potentialities is a complicated and important subject. It requires extensive knowledge of all diagnostic procedures necessary to evaluate the exact nature of the injuries and the probable consequences of natural healing

and degenerative changes over the remaining life of the patient. The expert must approach the case study with a completely open mind, determined to assemble all facts necessary for the establishment of correct diagnoses and complete comprehension of all matters relevant to the situation. Too often prejudicial factors resulting from biased attitudes, limited experience, preliminary prejudicial conferences with lawyers or adjusters, and hostile or ingratiating patient attitude consciously or unconsciously channel the conclusions which he reaches. This is particularly true where the objective findings are in contrast with the subjective complaints. Frequently this accounts for the wide disagreement between otherwise honest and sincere experts.

The history which the patient gives and his demonstrations of function must be subjected to close scrutiny. Inconsistencies and unusual findings must be noted and appraised carefully and an effort must be made to find their cause and classify them.

The most common form of inaccuracy on the part of the patient is exaggeration. This seems to become progressively greater as the case advances and the history is repeated to successive examining physicians. Misstatements entirely unsupported by fact are frequently made in order to establish an unfounded allegation. Headaches, dizziness, etc., are not uncommonly ascribed to cerebral concussions which never occurred. Momentary unconsciousness immediately after an automobile or other violent accident is referred to as a possible concussion reaction when as a matter of fact, the patient only fainted and had no physical trauma direct or indirect to the skull or its contents.

Many "back cases" of long standing and frequent recurrences offer themselves as fresh and primary injuries, and the physicians then wonder why they cannot be cured in the customary and usual length of time. The pitfalls in this field are legion. The physical examination must be sufficiently inclusive, not only to elicit and record all specific effects of the injury itself, but should

include an appraisal of the general physical condition of the patient. Accurate observations of the form and function are important and whenever possible, exact measurements should be made. In a low back examination, the question of the presence or absence of muscle spasm has often come into issue. True spasm beyond control of the patient is a significant finding. However, all too frequently, voluntary muscle contraction in response to the patient's will, or, reaction to faulty body mechanics and posture is causing spasm, and thus is given undue importance. Measurement of symmetrical parts of the body can be made a valuable feature of the physical examination. In the case of long standing disability in a knee, some degree of atrophy of the thigh muscles on the involved side would be a reasonable expectation. If such evidence were lacking, there should be a substantial basis of doubt, particularly where no other supporting evidence of disability could be identified. By the same token, callouses on the hands, uneven wear of shoes, localized atrophy, correlation of active and passive limitation of joint motion, x-ray changes which obviously antedate the duration of complaints are important data in estimating the claimant's status. Painful joints, if superficial, usually exhibit some degree of increased heat or redness or swelling.

Nature often achieves wonderful cures after the physician has exhausted his resources and

the claim has been adjusted or adjudicated. On the contrary, many situations such as joint and disc injuries deteriorate progressively, often leading to serious disability which was not considered or anticipated at the time of initial management of the case. It is the expert's duty and responsibility to understand, explain and weigh these potentials.

While injuries of the extremities readily lend themselves to classification and grading, those of the spinal column and head cannot be catalogued so easily. These latter injuries therefore fall into the group which are known as "non-schedule injuries." Permanent disability appraisal in these cases is based upon "the proportionate extent of the impairment of the injured's earning capacity in the employment in which he was working at the time of the injury, and other suitable employments."

At the conclusion of a competent examination, the expert should be able to set up a mosaic of evidence which either proves quite clearly that a real injury has occurred or show that the complete absence of such evidence or its utter inconsistency presumes that no significant abnormality is present. Even, given exactly the same facts, conscientious experts can and will disagree with regard to their significance and potentialities. Mere disagreement between experts does not imply dishonesty or incompetence on the part of one or both of them.

(Continued in May Journal)

BALTIMORE DEFENSE BLOOD CENTER

American National Red Cross
St. Paul and 23rd Streets
Baltimore 18, Maryland

It is necessary to increase the personnel of the Medical Staff of the Baltimore Defense Blood Center of the American National Red Cross. The salary is \$6600.00 a year, and the hours are from 9 A. M. to 5 P. M., Monday through Friday.

If interested, contact Dr. Courtney W. Shropshire, Medical Director, Baltimore Defense Blood Center, Hopkins 9905.

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THE HOSPITAL STANDARDIZATION PROGRAM

The Appointments to the Joint Commission on Accreditation of Hospitals and the various organizations which they represent, have been announced:

American College of Physicians:

Alexander M. Burgess, M.D., Providence, Rhode Island
William S. Middleton, M.D., Madison, Wisconsin
LeRoy H. Sloan, M.D., Chicago, Illinois

American Hospital Association:

Edwin L. Crosby, M.D., Baltimore, Maryland
Judge Milton George, Morden, Manitoba
John H. Hatfield, Philadelphia, Pennsylvania
Right Reverend Monsignor J. J. Healy, Little Rock, Arkansas
A. J. J. Rourke, M.D., San Francisco, California
Charles F. Wilinsky, M.D., Boston, Massachusetts

Canadian Medical Association:

E. K. Lyon, M.D., Leamington, Ontario
(A. D. Kelly, M.D., Toronto, Ontario, Alternate)

American College of Surgeons:

Arthur W. Allen, M.D., Boston, Massachusetts
Evarts A. Graham, M.D., St. Louis, Missouri
Newell W. Philpott, M.D., Montreal, Quebec

American Medical Association:

Gunnar Gunderson, M.D., LaCrosse, Wisconsin
L. W. Larson, M.D., Bismarck, North Dakota
Julian P. Price, M.D., Florence, South Carolina
Stanley A. Truman, M.D., Oakland, California
Herman G. Weiskotten, M.D., Skaneateles, New York
Rolland J. Whitacre, M.D., East Cleveland, Ohio

The Joint Commission held its first meeting on Saturday and Sunday, December 15 and 16, at the Drake Hotel in Chicago. Further details concerning the plan for the Joint Commission on Accreditation of Hospitals have been published in the Bulletin of the American College of Surgeons, 40 East Erie Street, Chicago 11.

Insurance

PRESIDENT'S REPORT TO THE BOARD OF TRUSTEES*

HUGH J. JEWETT, M.D.

The year 1951 was the first full year of operation for the Blue Shield Plan in Maryland. I believe we should look at it as an experimental period, one of trial and error, during the course of which we have been able to judge the effectiveness of the program and its acceptance by the Maryland community. We have made a good start in 1951 and have accomplished much, but it is clear that there is room for improvement and much more to be accomplished in the years ahead. We have only scratched the surface of our potential market.

First, let me relate briefly the highlights of our operations in the past year. As of December 31, 1951, we had enrolled a total of 57,472 persons under the standard Blue Shield program, or approximately $7\frac{1}{2}\%$ of the number of persons covered under Blue Cross. These subscribers were enrolled through some 1400 different employed groups and through a one-time offering to the Blue Cross subscribers paying on a direct basis. In retrospect, we had hoped for a higher enrollment figure at the end of the first year—some had predicted 75 to 100,000—but the results were nevertheless reasonably encouraging.

In addition, through a special national agreement with the Bethlehem Steel Company and its union, there has been in effect since September 1, 1951 a separate surgical indemnity program covering some 102,000 steel company employees and their dependents in Maryland. Actually, therefore, under the two programs we now have 160,000 persons eligible for Blue Shield benefits.

Our financial experience in 1951 under the standard program was favorable. Payments to physicians for benefits rendered took about 70¢ of the subscription dollar. However, because of the 12-month waiting period for obstetrical care and for tonsillectomies, very few such cases were covered in

the past year, and we can therefore anticipate a higher payment ratio in the year ahead. Administrative expenses paid to Maryland Hospital Service (Blue Cross) took 11.7% of subscription income, a relatively low percentage considering the heavy introductory expenses during the first year of Blue Shield operations.

Benefits were paid during the year to 4,710 subscribers, or about one out of every twelve enrolled. The Plan payments covered about 74% of the total cost of care as represented by charges made by physicians, and constituted full payment in 60% of the cases. Thus, while additional payments were required from about 40% of the subscribers receiving care because their incomes exceeded the established limits for service benefits, these payments totalled only one-quarter of the overall cost of care to subscribers.

So much for the 1951 results. Now I would like to review briefly the various factors which have prompted us to undertake certain revisions in the Plan, both as regards scheduled benefits and subscription rates. These revisions, as you know, were approved by the Board in January of this year, and are now awaiting approval of the State Insurance Department.

From the beginning, some difficulty has been experienced in selling the Blue Shield Plan on a voluntary basis. Presenting it to large groups with a majority of employees already enrolled in Blue Cross, it was found that an insufficient number of employees signed up for the new program to meet the required quota for formation of a group. Consequently, we have been able to enroll the employees of relatively few large companies on a voluntary basis. This is, of course, not true in those groups where the employer pays a part or all of the subscription charges.

The less-than-anticipated enrollment total during

* Annual Meeting of Maryland Medical Service, February 27, 1952.

the first year of operation can be attributed to several factors of varying importance. To some extent it has been due to the newness of the whole program and the slowness of the general public to fully understand and appreciate it. In part, it can be attributed to the fact that Blue Shield was late in starting in Maryland, and many companies already have a surgical coverage for their employees through a commercial insurance carrier.

Of major importance, however, have been three basic factors in the structure of the Plan itself, namely, (1) the high family rate in relation to the individual and husband and wife charge, and in relation to the Blue Cross rates; (2) the low income limits under which service benefits are provided; and (3) the peculiarities in the fee schedule arising from the category divisions.

There is not time here to discuss in detail these various points. Suffice it to say that the combination of them has had a retarding effect upon the enrollment picture. Two steps already have been taken to remedy this situation, namely, the proposed adjustments and revisions in the fee schedule and in

the subscription rates. A third step, an increase in the income limits for service benefits on the family coverage, will be presented to the Medical and Chirurgical Faculty at its April meeting. With these three changes, there is every reason to believe we will have a much more acceptable program.

I cannot close these remarks without extending my thanks and appreciation to the 1,560 physicians in the State who now are participating in Blue Shield and who have cooperated so splendidly during the first year of operations. It is encouraging to note that 150 of these physicians have signed participating agreements since the Plan started a year ago last November, and more are signing up every week.

With the adjustments that are being made in the Plan itself, and with the continued cooperation of the physicians throughout the State, I am confident that Blue Shield will be able to extend its coverage widely in the year ahead, thus taking its place beside Blue Cross as the community's accepted program for the provision of surgical and medical care on a prepayment basis.

ANNUAL GOVERNORS SAFETY AND HEALTH CONFERENCE

Baltimore, Maryland

May 8 and 9, 1952

The Industrial Nurses Section of the Annual Governors Safety and Health Conference will hold its meeting on Thursday, May 8, 1952, at 8 p.m. at the Lord Baltimore Hotel.

The theme of the meeting will be, "AFTER 60, WHAT?" The following will be the program: "Health and Psychological Aspects of Retirement" by Dr. Milton Landowne, Associate Chief Gerontology, National Institute of Health, Baltimore City Hospitals, and "Planning with the Employee for Retirement" by Rear Admiral Frederick Bell, U.S.N. Retired, Director of Human Relations, McCormick & Company, Inc., Baltimore.

The Program Chairman, Margaret E. Kramer, extends a cordial invitation to the physicians of Maryland to attend this meeting.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. LEWIS P. GUNDRY, *Corresponding Secretary*

OUR THIRD ANNUAL MEETING, at The Stafford Hotel, on Wednesday, April 30th from 10:00 A.M. through 3:00 P.M. will include a one hour luncheon, starting promptly at one o'clock. The doctors are also invited to attend and hear our speaker, Dr. Louis Krause. Plan to be present at this luncheon with your husband! In addition to the luncheon, our Annual Meeting Program will feature movies and exhibits for Auxiliary "Health Booths" at County Fairs, Round-Table Discussions, and a Fashion Show, not to mention our business meeting. Every member of the Auxiliary and all Faculty wives are urged to come. Write to the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland, for information if you do not receive a notice in the mail. Plan to come to your ANNUAL MEETING!

Arrangements for THE ANNUAL MEETING have been made by Mrs. Thomas A. Christensen, *Chairman of Arrangements*, and her Committee, Mrs. George G. Finney, *Decorations*; Mrs. M. Elliott Randolph, *Fashion Show*; Mrs. L. C. Dobihal, *Hospitality*; Mrs. R. Walter Graham, Jr., *Tickets*; Mrs. Albert E. Goldstein, *Publicity*; Mrs. Emil G. Bauersfeld, *Finance*.

The CREATIVE ARTS SHOW, on view April 28-30 at the Faculty Building, an exhibition of art work by our doctors and their families, was arranged by Mrs. Beverley C. Compton, *Chairman*, and her Committee: Mrs. Frank R. Smith, Mrs. Marius P. Johnson, Mrs. John W. Parsons, Mrs. Benjamin H. Rutledge, Mrs. Howard C. Smith, Mrs. I. Ridgeway Trimble, Mrs. Lawson Wilkins and Mrs. Walter L. Winkenwerder.

NEWS FROM COMPONENT AUXILIARIES

The Woman's Auxiliary to the Baltimore City Medical Society most graciously invited the entire membership of the Woman's Auxiliary to the Medical and Chirurgical Faculty to a State-wide meeting on Wednesday, April 2nd at 11:00 A.M. at the

Faculty Building, to meet Mrs. Harold F. Wahlquist, our National President, Woman's Auxiliary to the American Medical Association. A buffet luncheon followed. It was a privilege to meet this wonderful woman who represents us nationally. We are proud to claim Mrs. Wahlquist as our President! Our gratitude to the City Auxiliary for its hospitality!

The Woman's Auxiliary To The Baltimore City Medical Society also sent a delegation of its members to the City Hall, in Baltimore, on March 8th to a hearing on the fluoridation of water which was being opposed by certain organizations. Mrs. H. Hanford Hopkins and Mrs. George H. Yeager, Presidents respectively of the City and State Auxiliaries, also wrote letters favoring fluoridation and supporting the position taken by the Medical Societies.

The Baltimore County Auxiliary celebrated "Doctor's Day" on March 29th by having a dance at the Randallstown Community Hall, to raise funds for their second Nursing Scholarship. This represents a splendid effort and accomplishes the dual purpose of honoring the doctors and raising funds for a worthy purpose. Congratulations on a fine job!

Mrs. A. Austin Pearre, President of the Woman's Auxiliary to the Frederick County Medical Society reports that their recent, all-local Fashion Show was a tremendous success. Mrs. George H. Yeager, State President, and Mrs. Amos R. Koontz, Vice-President, who attended from Baltimore, were impressed by the enthusiastic reception. Tickets sold out early. Funds raised will go to their Doctors' Library.

The Auxiliary to the Washington County Medical Society surprised their Medical Society with a "Doctor's Day" luncheon. We understand that the party was enjoyed all the more for having been kept secret.

Prince George's also celebrated "Doctor's Day" with a luncheon for all their physicians, which was held on March 31st at the Prince George's General Hospital, and was served by Auxiliary members. The old custom of pinning a red carnation on each doctor in honor of the occasion was observed. This affair won favorable comment from every doctor.

A SMALL TOKEN

The Woman's Auxiliary to the Medical and Chirurgical Faculty pays one hundred dollars yearly to the Medical and Chirurgical Faculty towards clerical expenses incurred in its behalf at the Faculty Building. We are sorry that at present we can afford only this token payment and wish to express our thanks to both the Medical Society and its wonderful staff who have worked so hard to help us.

GOOD PUBLIC RELATIONS

MRS. A. S. CHALFANT, *Chairman*, Public Relations Committee

In his opening address at the recent Clinical Conference of the A.M.A. the President, Dr. John W. Cline, said, "The next year will be one of important decision. If we are to protect our heritage of freedom—this decision must be correct—it may not be easy to stop the progress toward socialism, but it is far easier to halt it now than to try to eliminate it after it has become an accomplished fact—the history of other nations clearly demonstrates that beyond a certain point there is no easy way of return—should this country continue on the road that leads to socialism, those things which we cherish will be irrevocably lost."

At the Public Relations Conference of the A.M.A. in December, Dr. Louis Bauer, the President-Elect, said in his keynote address, "The defeat of socialism must be accomplished at the community level because national opinion is the sum total of the public attitude of local communities." According to Dr. Bauer, "the tide can be turned in 1952, but we must *work* together to do it."

How can the Maryland Auxiliary help doctors educate the public to the fact that "your doctor's primary concern is to provide the finest medical care in the world"? One way is to make sure that the public, as well as the physicians, have access to information about our medical organizations, their services, their purposes and their goals. These organizations are not, of course, self-seeking unions, but exist to help doctors become better doctors, and to thus provide better medical service to our people. They are self-disciplining groups and as such most of them have "Grievance Committees," or "Pro-

fessional Ethics Committees" to which the public may appeal. The Public Relations Department of the A.M.A. suggests as a means of reducing public complaints: the discussion of fees in advance, explanation of extras (consultant's fees, etc.), itemized bills, budgetary help to patients for long-term medical care, the announcement that medical care is available, regardless of ability to pay, promotion of voluntary insurance and informing patients of the availability of catastrophic insurance plans, and the acknowledgment of complaints so that the patient knows the wheels of justice are turning. Another way is to thoroughly publicize your night call and emergency system. Also, the Auxiliary might send a card to all newcomers in the community listing the available medical services!

We can consciously develop better relations with the press and radio. We can see that our local newspapers are invited to or informed of our important meetings and projects. They are glad to publish items of local interest.

Auxiliary members, as well as doctors, should take a properly active role in various health campaigns and civic betterment projects. Those, who would socialize medicine, state that the doctors are a self-centered lot. We know that our doctors and their families are in the vanguard of every worth-while civic undertaking. See that this active community participation is properly recognized by the press!

Strengthen your Auxiliary by working to increase its membership. Educate your new members in Good Public Relations and put them to work promptly.

Plan now for your booth or tent at your County Fair. Your Medical Society will help and advise you. Perhaps your local National Guard will lend you a tent as a public service. Write to the A.M.A. for exhibits which illustrate the ways in which its services protect the health of the American people. You could make an exhibit of the services your State and local Medical Societies render. You would probably be surprised yourself at how many and how varied they are!

Another interesting study might be made of "What constitutes a *GOOD PATIENT*." This could well be based on your own experience as a doctor's wife similar to those related by Dr. Robert K. Webster, (Brazil, Indiana) in the Saturday Evening Post of November 17, 1951—"I'm a Doctor and I'm Human!"

If you will concern yourself with the wives of the young student doctors, who may or may not be members of the Junior A.M.A., you will help assure the future of your Auxiliary. They have problems and need the encouragement and interest of those who have had similar experiences. Always invite them to your meetings as guests of the Auxiliary.

Sometimes Public Relations opportunity comes from unexpected sources. Do not let them slip by you. Remember, your aim is to let people know that "your doctor's primary concern is to provide the finest medical care in the world."

AUXILIARY NURSING SCHOLARSHIPS

We are extremely proud to announce that nursing scholarships are either established or are in process of being set-up by the Auxiliaries to the Baltimore County, Prince George's County, Montgomery County, and Washington County Medical Societies! Baltimore County which scored a "first" by founding the first Auxiliary sponsored nursing scholarship in Maryland now has its second protégé starting in training! This is a wonderful way to help ease the nursing shortage and also to help a fellow human being attain a professional career.

DOCTORS' WIVES, BE INFORMED!

MRS. OMAR D. SPRECHER, Jr., *"Bulletin"*
Chairman¹

Pardon me, were you just passing through? It is so nice to meet a woman in the middle of a man's magazine. I did hope some of the women would get to this page. I've been waiting to visit a little with you.

"An informed Auxiliary is an efficient Auxiliary." Now there, you must remember where we've met before. Of course I'm your Bulletin Chairman. I gave a short talk at the last Auxiliary meeting on why we should subscribe and read the Bulletin of the Woman's Auxiliary to the American Medical Association. You had to leave the meeting a little early and I didn't get your subscription. I did call you on the phone but always seemed to just miss you. I really wanted to tell you why I think you should subscribe to our Bulletin.

¹ Bulletin Chairman for the Bulletin of the Woman's Auxiliary to the A.M.A.

First, our motto for 1952 is "An informed Auxiliary is an efficient Auxiliary." Next I find that today Auxiliary leaders are saying "The improved Bulletin has been a revelation to me—I look forward to the receipt of each issue so that I can read and study our officers reports, and keep abreast of Auxiliary progress. I find it invaluable for my files and future references."

Why not slip one of those "fifty cent" dollars to your Bulletin Chairman today? Tomorrow you will have forgotten the expenditure, but the pleasure of receiving the Bulletin will last for one year.

MEDICAL RESEARCH EDUCATION

Our Chairman of Medical Research, Mrs. R. Walter Graham, Jr., hopes that the Auxiliary will place the speakers, movies, and exhibits offered by the Maryland Society for Medical Research, wherever we can before groups; in schools, and at the County Fair "Health Booths," this summer! In this way we can educate people to the needs of research. Our job is to secure an audience for the very fine program outlined below by Dr. Dietrich C. Smith, secretary of the Maryland Society for Medical Research! (Society Headquarters are at 29 S. Greene Street, Baltimore 1, Maryland.)

THE PROGRAM OF THE MARYLAND SOCIETY FOR MEDICAL RESEARCH

DIETRICH C. SMITH, PH.D.²

Your Auxiliary is cooperating with the Maryland Society for Medical Research! The educational program of this Society is designed to acquaint the people of Maryland with the cost, needs and goals of medical research as carried out in this State and elsewhere. It emphasizes the fact that the public can most effectively support medical research by supporting the medical schools and that it is only by fostering fundamental research, that applied research will continue to give mankind new drugs, new treatments and new surgical techniques. To this end the medical schools and research institutions must be supplied with proper tools in the form of adequate funds, equipment, personnel and animals.

² Professor of Physiology, School of Medicine, The University of Maryland.

To achieve these goals the Maryland Society for Medical Research has adopted a program of supplying qualified speakers on the various facts of medical research for meetings of clubs, societies, schools, churches, and other civic organizations. It also supplies speakers for vocational guidance groups in the schools and colleges outlining the careers and opportunities open in medical research. The Society arranges conducted tours through the laboratories in Baltimore of selected groups of students from science classes and clubs.

In addition, it publishes a quarterly Bulletin describing the activities of the Society to its members and other interested persons. It has produced and exhibits a motion picture film entitled, "Frontiers

in Medical Research," showing the medical research institutions in Baltimore, the kind of animals they use and some of the research procedures. Other motion picture films dealing with various aspects of medical research are also available.

The Society is supported by dues and contributions of its members who are drawn from all walks of life throughout the City and State. It is not a fund raising organization and does not propose to conduct or sponsor any fund raising campaign among the general public! It is prepared at any time to fight actively for any legislation that will further its goals and is equally well prepared to fight against any legislation that it believes will hinder the advancement of medical research.

NEW EFFORT UNDER WAY TO GET PRIORITY I PHYSICIANS TO JOIN RESERVES

Capitol Clinic, A. M. A., Vol. 3, No. 11, March 18, 1952

A new effort is being made to induce about 1,000 physicians rated in Priority I of the doctor-draft to sign up for service in the military reserves. Men involved were educated at government expense during World War II or deferred from service to continue their medical educations, but so far have not applied for reserve commissions.

National Advisory Committee to Selective Service (Dr. Howard A. Rusk, Chairman) declares: "Various state committees, as well as the National Committee, have been deeply concerned over these individuals who did not at the time of special registration apply for a commission and have not subsequently done so *while other more willing individuals have accepted commissions and many of them are now serving in the armed forces.*"

Selective Service Director Louis B. Hershey says these "inequities" can only be prevented by calling up physicians through Selective Service (not the reserves).

The acting chairman of *Defense Department's Medical Policy Council*, Dr. Melvin A. Casberg, warns: "When all Priority I type reserves have been called to active duty . . . the Selective Service System will be requested to bring the remaining Priority I registrants into service before any Priority II type reserves are called. *It is anticipated this will occur within the next six months.* Hence, the recalcitrant ones are only delaying their service until all Priority I registrants who have accepted commissions are called up."

Meanwhile, Defense Department has announced that 290 medical reserve officers will be called to active duty in July. Included will be 135 physicians. All are Priority I type reserves and will serve for two years.

MARYLAND SOCIETY FOR MEDICAL RESEARCH

DIETRICH C. SMITH, PH.D.¹

The Maryland Society for Medical Research is now in its second year as an active working organization dedicated to informing the people of the State concerning the needs of its medical research institutions. It is actively seeking new members and hopes to enroll all of the physicians in the State. An exhibit describing the work of the Society will be on display at the forthcoming meeting of the Medical and Chirurgical Faculty at the Faculty Building in Baltimore April 28-30. The Society depends entirely upon dues and contributions from its members to carry on its work.

The Society was incorporated in 1950 and during the first year of its existence organized the opposition to the antivivisectionist-sponsored amendment to the City Charter forbidding the use of impounded dogs for experimental purpose by the research institutions in Baltimore City, and establishing a so-called Humane Commission with the power to investigate the use of animals in medical research. With the help of thousands of public spirited citizens it brought this amendment down to ignominious defeat, the 4 to 1 vote against the amendment in Baltimore being the highest ever obtained by the friends of medical research on this issue at any election in the country.

With this victory behind it the Society had no intention of resting on its laurels, but instead turned its attention to implementing its long-term educational program and has been quietly working on this objective ever since. Among the many activities it has sponsored, are conducted tours through some of the local research laboratories, for science classes and clubs from the high schools in the immediate area and vocational guidance programs explaining the opportunities open in medical fields to groups in the public schools. It also maintains a speaker's bureau which will supply any interested organization

with a speaker on any topic related to medical research. A Bulletin is published quarterly giving news in regard to the various activities the Society sponsors and encourages, as well as news concerning the progress of similar organizations throughout the country. The recent passage of a bill by the New York Assembly, after a long and bitter fight, permitting medical schools in that state to have access to impounded dogs is reminiscent of the struggle in Baltimore and is a heartening sign that an understanding of the issues involved is spreading among the general public. It also underlines the necessity for continuing educational work so that gains here and elsewhere will be held.

One of the more ambitious projects undertaken by the Society during the past year is the production of a motion picture film entitled "Frontiers in Medical Research" in color and sound. This film is now complete and available for showing to any interested group on request to the Society's headquarters, 522 West Lombard St., Baltimore 1, MUlberry 5348. The picture runs for twenty-five minutes and shows scenes, both exterior and interior, of the various medical research institutions throughout the City; the types of animals used in experimental work and some of the more common laboratory procedures employed. The use of anaesthetics in animal research is especially stressed, as is the care and feeding of the animals in the kennels of the various local research institutions.

The Society is particularly anxious to show this film before as many groups throughout the State as possible. Any physician in any community who is asked to organize a medical program for local civic, church or school group and who wishes help or assistance should feel free to call upon the Society. The Society would welcome the opportunity to arrange for the exhibition of its film, or to arrange for any other type of program within the scope of its activities for non-professional groups.

¹ Professor of Physiology, University of Maryland School of Medicine; Secretary, Maryland Society for Medical Research, Inc.

Component Medical Societies

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

ANESTHESIOLOGY SECTION

OTTO C. PHILLIPS, M.D., *Chairman* EDWARD I. LEDERMAN, M.D., *Secretary*
Monday, May 5, 1952, 8:30 p.m.

Current Trends in the Practice of Anesthesiology. Edward B. Tuohy, M.D., Past President of the American Society of Anesthesiologists, Inc.; Professor of Anesthesiology, Georgetown University School of Medicine, Washington, D. C. (By invitation.)

RADIOLOGICAL SECTION

J. HOWARD FRANZ, M.D., *Chairman* RICHARD B. HANCHETT, M.D., *Secretary*
Tuesday, May 20, 1952, 8:30 p.m.

Brief meeting for conclusion of annual business.
Election of officers.

ORTHOPAEDIC SECTION

JESSE N. BORDEN, M.D., *Chairman* EDMOND J. McDONNELL, M.D., *Secretary*
Monday, May 26, 1952

Program, time and place to be announced.

PATHOLOGY SECTION

WILLIAM V. LOVITT, JR., M.D., *Chairman*

JOINT MEETING WITH THE MARYLAND SOCIETY OF PATHOLOGISTS, INC.

This meeting will be held at the National Cancer Institute, Bethesda, Maryland.
Program and date to be announced.

ROYALTIES FOR AMERICAN MEDICAL EDUCATION FOUNDATION

Secretary's Letter No. 209, February 18, 1952

A. M. A. President John W. Cline said the A. M. A. Board of Trustees had approved in principle a plan whereby the A. M. A., as a corporation, would accept patents for medical discoveries made by member physicians. All Royalties, he said, would be turned over to the *American Medical Education Foundation* for distribution to medical schools.

MARYLAND ACADEMY OF GENERAL PRACTICE

Hotel Alexander, Hagerstown, Maryland

Thursday, May 15, 1952

PRELIMINARY ANNOUNCEMENT AND PROGRAM

10:00 a.m. to 12:00 noon

Registration and technical exhibits.

Medical film in color and sound:

1. Urinary tract infections—time 35 min.
2. Cervicitis—time 50 min.
3. Anti-coagulant therapy—time 32 min.

12:00 noon to 1:00 p.m.

Completion of registration, informal luncheon.
(Luncheon not included in registration fee.)

1:00 p.m. to 5:00 p.m.

ON CARCINOMA PRESENTED BY PROMINENT MEMBERS OF THE FACULTY OF THE UNIVERSITY OF PENNSYLVANIA UNDER THE DIRECTION OF DOCTOR I. S. RAVDIN.

1:00 p.m. to 2:00 p.m.

Carcinoma of the Thyroid.

Dr. Robert C. Horn
Dr. Richard H. Chamberlain
Dr. I. S. Ravdin or Dr. William T. Fitts, Jr.

2:00 p.m. to 3:00 p.m.

Carcinoma of the Colon.

Dr. Thomas E. Machella
Dr. Richard H. Chamberlain
Dr. William T. Fitts, Jr.

3:00 p.m. to 4:00 p.m.

Carcinoma of the Pelvic Organs.

Dr. Franklin L. Payne
Dr. Douglas P. Murphy
Dr. Robert C. Horn, Jr.

4:00 p.m. to 5:00 p.m.

Carcinoma of the Lung.

Dr. Richard H. Chamberlain
Dr. Joseph F. Atkins
Dr. Julian Johnson

5:30 p.m. to 6:00 p.m.

Cocktails at the Hotel Alexander.

6:30 p.m.

Banquet, Hotel Alexander. The name of the speaker will be announced later. Paper will be on a non-technical subject.

LADIES AFTERNOON PROGRAM: Arrangements are being made for entertainment of the ladies attending at the Country Club; plans include luncheon and a diverse program.

REGISTRATION FEES:

Scientific session only.....	\$3.00
Scientific session, cocktails, banquet....	\$7.00
Ladies luncheon and afternoon program.	\$1.50
Ladies attending cocktail party and banquet	\$4.00

There will be no fee for attendance at the scientific session for wives of physicians attending, medical students, interns, residents and members of the allied professions.

For further information write to Dr. William T. Layman, Hagerstown, Maryland.

THE MARYLAND SOCIETY FOR MEDICAL RESEARCH NEEDS YOUR SUPPORT

VISIT THE EXHIBIT AND ENROLL AS A MEMBER

AT THE ANNUAL MEETING IN BALTIMORE

APRIL 28-29-30

EXCERPTS FROM CAPITOL CLINICS, A. M. A.

NATIONAL ADVISORY COMMITTEE CAUTIONS HOSPITALS ON SELECTING RESIDENTS

Capitol Clinic, A. M. A., Vol. 3, No. 6, February 12, 1952

National Advisory Committee to Selective Service advises hospitals to attempt to select their residents for 1952-53 *in the reverse order of their priority under the Doctor-Draft law*, with none chosen from Priority I "except under very exceptional circumstances, and probably in no instance except where there is a question of servicing an isolated community hospital." The Committee also reiterates that information on registrants, submitted for the purpose of reopening their cases, must come from the *chairman in the state* in which the individual is engaged in his professional activities and must be addressed to the man's local Selective Service Board. The National Committee explained that information on the registrant should come from the *state chairman* rather than the *local committee* where he is located to avoid "putting one hospital out of line" with the other hospitals in the affected city.

MRS. ROSENBERG SAYS DEPENDENTS OF SERVICEMEN ARE GETTING LESS MEDICAL CARE

Capitol Clinic, A. M. A., Vol. 3, No. 5, February 5, 1952

Testifying in favor of the military pay raise bill, Assistant Defense Secretary Anna Rosenberg said the military services currently are able to give medical care to *fewer dependents* than in past years. She gave this as one reason why a pay increase is justified.

Technically, medical care is authorized for dependents *only when professional personnel and facilities are "available."* Mrs. Rosenberg explained that the present situation had developed because of (a) increasing numbers of military personnel who have first claim to medical care, (b) shortages of professional personnel and facilities, particularly hospital beds, and (c) the necessity for keeping large numbers of beds ready for Korean casualties.

Also, Mrs. Rosenberg said the military departments' medical budgets were so low as to leave little money to provide care for wives, children and other dependents. For fiscal 1953, she declared, military departments were budgeted at an average of \$120 or less for each uniformed member for a year's medical care (Army \$107, Navy \$120 and Air Force \$117). Construction and maintenance costs of hospitals are not included in the totals.

HOUSE COMMITTEE CUTS VA MEDICAL BUDGET

Capitol Clinic, A. M. A., Vol. 3, No. 11, March 18, 1952

House Appropriations Committee has cut Veterans Administration administrative and medical budget for fiscal 1953 by \$91.5 million—\$20 million less than budgeted for purchase of drugs and medicines, \$4 million less for medical and dental fees which the Committee says are "too high," and \$1.5 million cut in alteration and repair funds.

SENATE HEALTH SUBCOMMITTEE ACTION ON EMIC BILLS PROMISED 'FAIRLY SOON'

Capitol Clinic, A. M. A., Vol. 3, No. 11, March 18, 1952

Chairman Lehman (D., N. Y.) of Senate Health subcommittee looks for action "fairly soon" on bills providing *medical, nursing and hospital care for mothers and infants of servicemen in the seven lowest pay grades*. He made the statement at close of hearings on bills sponsored by himself and Senator Humphrey (D., Minn.). Lehman bill also would provide hospitalization for dependents.

Most witnesses supported one or both bills and Children's Bureau estimated that 200,000 babies will be born yearly to wives of enlisted men. Defense Department and Bureau witnesses agreed that between 75,000 and 80,000 of these cases could be handled in military hospitals. Accepting the figure of 200,000, *the question is: how many of the remaining 120,000-125,000 cases cannot be handled by existing facilities, public and private?*

A. M. A. witnesses, opposing both bills, maintained that need for an EMIC program has not been demonstrated. (Text of testimony by Dr. Martha Eliot, Children's Bureau chief, appeared in SPECIAL BULLETIN No. 11; texts of A. M. A. witnesses in SPECIAL BULLETIN No. 12 and summary of testimony of all witnesses will appear in SPECIAL BULLETIN No. 13.)

ONLY FOUR 'CRITICAL TARGET' STATES NOT ACTIVE IN CD MEDICAL STOCKPILING

Capitol Clinic, A. M. A., Vol. 3, No. 7, February 19, 1952

Federal Civil Defense Administration's medical supply stockpiling program now is moving ahead after a year of delays, mostly due to reluctance of some states to appropriate matching money. As late as December 1, CDA reported that 15 states containing critical target areas had not yet entered the program. Within the last two months, however, *all but four of these either submitted acceptable plans to Washington or are busy working out plans*. The funds, matched by states, will be spent for emergency medical supplies, to be stockpiled locally for use immediately after an attack.

CDA disclosed that the situation was changing for the good in announcing allocation of more than \$8 million to 14 states for local medical stockpiles, including such items as burn dressings, litters, blood plasma, antibiotics and surgical instruments.

States already participating in the program, with total budgets for each are:

California	\$3,984,638	Maryland	\$ 398,231	Oregon	\$ 15,504
Colorado	39,632	Massachusetts	298,674	Rhode Is.	3,766
Connecticut	303,903	Michigan	793,707	Tennessee	197,430
Delaware	50,275	New Jersey	552,360	Washington	498,666
Kansas	97,549	New York	9,486,896		

Although states are paying half the costs, most of the funds will be expended through CDA, to take advantage of bulk purchasing while at the same time not exceeding the capacity of manufacturers. Federal Civil Defense Administration also has about \$33 million available for setting up and maintaining regional warehouses for medical supplies. These stocks, *paid for entirely by U. S.*, will be held in reserve, to be rushed in to an attacked area to supplement local supplies after the first few hours.

THE FACULTY BUILDING WILL BE CLOSED MEMORIAL DAY,
FRIDAY, MAY 30, 1952

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 1

May, 1952

NUMBER 5

EDITORIAL

SOMETHING TO VOTE ABOUT

American citizenship may be acquired in the delivery room or the courtroom, but it is fully achieved only in the daily realization of those privileges and duties that give man his rightful place in society. Yet when it comes to voting—the keystone of citizenship—Americans in the past have had a tragic apathy.

In 1948 there were approximately 96 million eligible voters in the United States. But in that year, only 49 million—about half of the eligible voters—cast ballots in the Presidential election! And the turnout at the polls has been decreasing!

Such a record in America, where free elections protect the rights and liberties of the individual, is more threatening to our freedom than any threat from abroad.

In recent elections, according to the Saturday Evening Post,* the voters in leading countries exercised their right of franchise as follows:

Belgium.....	90 per cent
Italy.....	89 per cent
Great Britain.....	82 per cent
France.....	75 per cent
Japan.....	70 per cent
United States.....	51 per cent

Why are Americans so apathetic? Why do so many of us sit back and “let George do it”? Perhaps it isn’t apathy. Perhaps it is basically an unawareness of issues.

Japan had a new-found individual freedom when 70 per cent of its voters cast their ballots. France and Belgium had just dropped the Nazi yoke. England turned to Churchill after years of Socialist rule. Italy arose against Communist infiltration. People in those Nations really had something to vote about.

Americans have something to vote about, too. Daily the issues are growing more clearly defined. The world needs a strong, sure America—and only Americans can keep our Nation strong.

Our role is clear. Whatever path we want America to take, we citizens at the grass roots must make the choice. We must study the issues. We must decide. We must vote. And as good citizens, we must do everything in our power to see that others register and vote, too—because today we Americans, of all the peoples of the world, have something vital to vote about!

* January 12, 1952. Pp. 10, 12.

Reports

COMMITTEE ON RURAL MEDICINE

SUMMER PRECEPTORSHIP JUNIOR MEDICAL STUDENTS

The Committee on Rural Medicine is considering a summer preceptorship for Junior Students to rural practitioners. Any rural practitioner who is interested in securing a junior student to assist him through the summer months and is willing to pay him should contact Dr. Page C. Jett, Chairman, Committee on Rural Medicine, Prince Frederick, Maryland.

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee for the Study of Pelvic Cancer met in the Small Hall of the Medical and Chirurgical Faculty Building at 5 P.M. on March 20th, 1952. The following members of the Committee were present: Dr. Richard W. TeLinde, Chairman; Dr. Beverley Compton; Dr. C. Bernard Brack; Dr. Everett S. Diggs; Dr. Howard Jones, Jr.; Dr. Theodore Kardash; Dr. Emil Novak; Dr. Mark V. Ziegler. Total attendance 22.

For the benefit of the doctors attending the meeting for the first time, Dr. TeLinde explained that the purpose of the Committee is educational and not critical. It is the hope of the Committee that all may profit by the free discussion of cases.

CASE DISCUSSIONS

CASE I. M. D. White. Widow. Age 49 years. Para. 1. April 1950 onset of excessive vaginal bleeding for two days; two days later bleeding again for two days. Reported to clinic—was examined—Rx. hospitalization for biopsy and probably hysterectomy. Operation 5/16/50: D. & C.; hysterectomy; bilateral salpingo-oophorectomy. At operation found to have squamous cell carcinoma of cervix, Grade II. Readmitted to hospital July 1950 to attempt radium to cervix. The cervix was so destroyed by disease that radium was not used and x-ray advised. Had series of fifty x-ray treatments. Hospitalized for five weeks November—December 1950—thrombophlebitis. Occasional spotting since operation in May 1950 but never in any great amount until one week before admission to second hospital in November 1951. Saw doctor A in interim—last time September 1951—was examined and fur-

ther x-ray advised but patient could not afford this. Reported to gyn. clinic of second hospital November 1, 1951. Four days later, when having profuse bleeding, came to accident room of second hospital and was admitted to the hospital. Diagnosis: Squamous cell carcinoma, cervix. Radium.

Chairman: Is there any discussion of this case?

Guest surgeon: This patient consulted her family doctor soon after the second episode of bleeding and was immediately referred to the hospital. On pelvic examination we found that she had a large mass on the left side of the pelvis, and a large mass also on the right. Although she had been referred because of a fibroid we felt that she had far advanced P.I.D. of a type not often seen these days. At the time of operation we did the D. & C. first. The cervix looked normal and the tissue looked normal. We proceeded with the abdominal operation. A large hydrosalpinx was revealed on the right and also a large mass on the left. When deciding whether to do a panhysterectomy or a supra-vaginal hysterectomy a large mass was felt in the cervix which was considered stage II, or possibly stage III, carcinoma of the cervix. The decision as to what to do was difficult. We debated leaving the uterus in but felt that the blood supply to the uterus had already been embarrassed. There was so much pathology in the upper pelvis that it was decided to go ahead with the fundectomy and bilateral salpingo-oophorectomy. I would like to note, because it is not on your abstract, that the

patient had a 4 plus Wassermann. I feel that I made two mistakes in this case: (1) not taking a biopsy first, even though the cervix looked normal; (2) taking off the fundus. The patient was referred to a radiologist after her discharge from the hospital. It is my understanding that the patient had x-ray before her admission to the hospital for attempted radium insertion. The services at the hospital changed soon after the patient was operated on in May and I did not see her again.

Chairman: We are very glad that you came to the meeting today. You have presented just the facts that we want to know. Unfortunately this was an inverting type of tumor where the cervix can look normal. I would like to ask what was the hurry? Why not wait for a biopsy report?

Guest surgeon: It would certainly have been wiser to wait for a biopsy report. In this case the family doctor thought the patient had a fibroid, we thought she had P.I.D. That was the pre-operative diagnosis.

Visiting surgeon: If a patient is bleeding, has a fibroid, but a normal cervix, is it necessary to waste time before doing a hysterectomy? In our hospital over a period of five years and 1200 hysterectomies there has been only one case of carcinoma discovered which was not known pre-operatively.

Chairman: Certainly we have to be practical about this. On our service, however, a biopsy is done on all women on whom a hysterectomy is contemplated, and we wait for the result.

Committee member: I feel the more biopsies done, the better it is. The same applies to smears. The service here on smears is good but slow unfortunately. There is a delay of about four weeks before the report is available.

Visiting pathologist: In our hospital over the past year there has been only one case of carcinoma detected at operation and not known pre-operatively. I do not know the exact number of cases but it would be between two and three hundred.

Visiting surgeon: If adenocarcinoma of the fundus is found at operation, would you follow with deep x-ray therapy?

Committee member: We would not unless there was obvious spread of the disease. If there was spread of the disease well into the parametrium, we would use x-ray.

This was the consensus following some discussion of this question.

Visiting surgeon: In the case we have under discussion, I would like to ask if the patient had any treatment from the time of operation in May until the attempted radium in July?

Chairman: We have a letter from the radiologist which states that the patient had twenty-eight x-ray treatments between June 5, 1950 and July 7, 1950, using two anterior and two posterior ports, and using routine 200 KV technique and giving 250 r as measured in air at each treatment. Of the attempted use of radium he says, "all ordinary anatomical landmarks were completely obliterated and I thought it good judgment not to place radium into what remained of the vaginal vault. Between July 17, 1950, and July 29, 1950, I gave her eight intra-vaginal and four perineal x-ray treatments. Altogether she received 5000 tissue r to the cervix and parametrial area. . . . The patient returned to me again on June 11, 1951. At this time there was an obvious gross recurrence. Between June 11, 1951, and July 5, 1951, I gave her twenty more external x-ray treatments as a palliative measure. I did not see her again."

It is noted on the abstract of this case that the patient was advised to have further x-ray in September 1951, but stated that she could not afford this. Not in reference to this case, but just by way of information I would like to say that there are some funds available through the American Cancer Society for treatment.

Visiting surgeon: Would it have been advisable for this patient to have further x-ray? It is the usual belief that when a patient has had sufficient x-ray the second dose does no good.

Committee member: There is good salvage but terrific radiation reaction after passing the critical dose.

Case I: No Delay.

CASE II: E. C. White. Age 68 years. Married. Para 4. Menopause, 1934. About December 10th, 1951, sudden profuse brownish vaginal discharge, followed by intermittent vaginal bleeding. Consulted doctor A a few days after onset of symptoms—was not examined—pills prescribed. Consulted this physician again in late December—was not examined. Consulted doctor B January 10th, 1952—was examined and hospitalization recommended. D. & C. and biopsy February 5th, 1952. Referred to second hospital for treatment. Diagnosis: Carcinoma of the fundus. Radium. Panhysterectomy.

Chairman: Unfortunately the doctor who first saw this patient is not present today. This case follows

a pattern we see all too often. The patient consults a physician, is not examined and pills are prescribed. The patient does not improve, consults another physician and immediately receives proper examination and treatment.

Case II: Physician Delay.

CASE III: F. R. Colored. Age 16 years. Single. Patient seen in gyn. clinic July 16, 1951, with complaint of "dizziness, knot in thigh, pains in stomach." Pelvic negative. Impression: "Femoral hernia; adenitis with cyst. formation." L.M.P. October 1951. Patient thought she was pregnant; felt weak and ill. Consulted doctor A, November 1951. Was examined and told that she was not pregnant but that she had low blood pressure and "inflammation of the stomach." Treated with oral medication and penicillin injections. Saw doctor A four times. Continued to feel ill. No menses except for one day in December. Went to second clinic January 25, 1952. Ectopic pregnancy suspected and patient was referred to the hospital and hospitalized the same day. Diagnosis: Retro-peritoneal lymphosarcoma. Exploratory laparotomy January 28, 1952. X-ray.

Committee member: I happened to be at the second clinic the day this patient presented herself. She gave a history of not menstruating for about three months. A mass could be felt in the abdomen adjacent to the left inguinal canal. On pelvic there was no evidence of a pregnancy of three months. The first impression was a possible ruptured ectopic pregnancy which was walled off. The patient looked ill and was referred to the hospital immediately. I did not examine the extremities and did not know of the mass in the thigh at this time. We did not expect a malignancy in this sixteen year old girl with amenorrhea.

Committee member: The record does not say whether or not the patient was referred to the surgical clinic after she was seen in the gyn. clinic in July with the impression of "femoral hernia." Knowing the patient it is possible that she was referred and did not keep the appointment. She should have been referred to surgery. The mass, of course, proved to be the sarcoma presenting into the inguinal canal.

Chairman: This is an unusual case and everyone probably did the best they could. I do not believe we can say there was delay here.

Case III: No Delay.

CASE IV: M. F. Colored. Age 71 years. Widow. Para 3, 1 miscarriage. Menopause about 1920. Beginning in October or November 1949, slight vaginal discharge. February 1950,

slight vaginal spotting, intermittent but increasing in amount. Consulted doctor A in February 1950. Was examined and told there was nothing wrong. Bleeding increased and by June 1950 was almost continuous. Again consulted doctor A and was referred to the hospital June 1950, and hospitalized. Diagnosis: Adenocarcinoma, corpus uteri, Grade III. Radium. Hysterectomy, total abdominal; suture of cervix; salpingo-oophorectomy, bilateral.

Question raised as to why the suture of the cervix after radiation therapy had been carried out. It was felt that in some cases where this is not done that there can be a vault recurrence.

There was a long discussion of "that American institution," the insistence on preliminary radiation in carcinoma of the fundus. The consensus was that there is a higher percentage of salvage when radium is used as an adjunct to surgery.

Visiting surgeon: Then why do we not follow the same line of thought in treating Stage I carcinoma of the cervix? I mean a total hysterectomy, not a Wertheim, following radiation.

Chairman: It seems to me that if spread beyond the cervix is trapped by fibrous tissue that opening up the abdomen would be the worst thing you could do.

Committee member: If the case does well with radiation it is better to let it stay as it is.

Case IV: Patient and Physician Delay.

CASE V: M. E. White. Age 54 years. Married. Para 7. L.M.P. July 1950. Patient had an appendectomy April 1951. About one month after operation began to have scant, intermittent bloody vaginal discharge. Beginning August 1951, profuse foul-smelling watery discharge. January 15th, 1952, profuse vaginal bleeding with large clots. Consulted doctor A—was examined and referred to hospital for D. & C. and biopsy by doctor B. Biopsy January 21st, 1952 showed squamous cell carcinoma. Patient referred to doctor C for treatment. Admitted to second hospital January 27th, 1952. Patient found to have a vesico-uterine or vesico-cervical fistula. February 5th, 1952, D. & C. and biopsy by sharp coagulation; exploration of fistula. Pathological report "carcinoma in situ" . . . "one fragmented area suggestive of invasion." February 11th operation: Cystotomy; biopsy of bladder; bilateral ureterosigmoid implantation. Post-operative diagnosis: Carcinoma of cervix; carcinomatous and traumatic fistula, cervico-vesical. Patient to be treated later with radium and x-ray.

Guest surgeon: This patient had an appendectomy, according to her history, on April 27th, 1951. The brief abstract which I have received from the hospital states that the physical examination was essentially normal and that the pathological findings

at operation showed a scarred appendix. It was not stated whether or not a pelvic examination was made at this time.

Chairman: I believe we have a note from the hospital saying that according to the history and physical taken at the time of admission there was no pelvic examination done.

Guest surgeon: A month to six weeks following the operation the patient began to have an occasional bloody discharge from the vagina and in August 1951 began to have a profuse, foul-smelling watery discharge. Following profuse bleeding on January 15th she was sent into a hospital for a D. & C. and biopsy. The doctor who performed the D. & C. told me that he felt he had perforated the uterus at the time of operation. The patient was catheterized and blood-stained urine was obtained but when methylene blue was introduced into the bladder to determine the presence of a possible fistula, no dye leaked into the vagina. Cystogram examination the next day was read as normal. Three days following discharge from this hospital I saw the patient for the first time. At that time she was pouring urine

from the vagina but I could not see the fistulous opening. She was admitted to the hospital. On examination, milk put into the bladder came through the vagina. The first two biopsies done showed chronic cervicitis. On re-reading the slides from the original biopsy at the first hospital it was thought there was some evidence of carcinoma in situ. The third biopsy at our hospital was as stated in the abstract. The patient was operated on as stated, and will be treated with x-ray and radium. We are treating her as invasive carcinoma.

Committee member: I would like to ask why the bladder was opened at the time of operation?

Guest surgeon: With the idea of closing the fistula if that seemed possible. The fistula proved to be too large.

Committee member: Did the biopsies from the fistulous tract show carcinoma?

Visiting pathologist: No, the biopsies from the fistula were not positive for carcinoma.

There was discussion of the urological problems involved in this case and the advisability of doing a cystotomy at the time it was done.

COMMITTEE TO COOPERATE WITH THE AMERICAN MEDICAL EDUCATION FOUNDATION

NEWLAND E. DAY, M.D., *Chairman*

At a really stimulating meeting of the American Medical Education Foundation, February 17th in Chicago, Maryland physicians will be proud to know that they have no need to apologize for the interest they have already shown in the Foundation. In spite of its size, your Chairman of the State Committee was informed that we were fifth from top place in contributors of all the States from January 1, 1952 to February 14, 1952.

The Faculty's activation of this Committee took place in late December past, a move which had been delayed in the past year by other local and pressing needs such as our own Building Fund Campaign so ably directed by Dr. Goldstein. Following the appointment of a Chairman and City and County members, an initial letter outlining the purpose of the American Medical Education Foundation with a request for support was made with the knowledge

that Maryland doctors when they are given the facts know where their duties rest and will not shirk them.

The initial response was most gratifying. Many who gave generously, not only contributed but wrote that they were "happy" to give, to a program that helped to save their corner of America for others to come. The spirit of the givers was of more significance than even the totals reported. Members of the Medical and Chirurgical Faculty gave before an explanation was furnished that contributors to the Foundation may select the recipient of their gift as follows: (1) " earmark " it for any accepted Medical School of their choice, (there is no deduction for administrative expenses) or (2) authorize the Foundation to distribute the gifts to all medical schools on a proportionate basis.

The American Medical Association pays the bill

for administration. It is possible for your Alumni Association and yourself to be given the credit for any gift and the Foundation at the same time is also helped. There are many private organizations willing (and already pledged) to match the Medical Profession's contributions. The gift is *Tax Deductible*. Maryland reported that in the period from January 1, 1952 to February 14, 1952, contributions totaling over \$1,027.00 had been forwarded to the Foundation.

State reports were preceded by an address of welcome by the President of the A.M.A., Dr. E. L. Henderson, who is also President of the A.M.E.F. This was followed by an address by Dr. James E. Almond, a pioneer in the field of fund-raising for American Institutions. In the afternoon the goal, the plan and the mechanics of the American Medical Education Foundation were explained.

Colorado, with 1100 members in its State Society contributed \$8,000.00. In Indiana, one county alone with only 18 members pledged over \$1,300.00, another county also of 18 members pledged \$1,800.00. Emphasis was placed on each member's contribution and not totals. Thus far this year Indiana has reported 383 contributors with total contributions of over \$20,000.00

In 1951, America's 6,135 new doctors of medicine paid only 25% of the cost of their medical training. It cost more than \$13,356 to train each of them. Most of this differential represents medical schools operating deficits, which we as a profession must help meet, or it will be done by other groups less concerned with the problems of the individual schools and doctors and more concerned with an increasing concentration of power.

In July, 1951, the American Medical Education Foundation made grants to every recognized medical school in America under the following classifications. Class A schools received uniform grants (\$15,000.00 to each school in 1951) across the board regardless of special needs. Class B schools received grants of money on a per capita basis of student enrollment.

Class C schools participated in a special fund contribution on the basis of special or unique problems of financial strain. This latter class showed benefits out of all proportion to the amounts given. In many instances it meant the difference in keeping key teaching and allied personnel. FUNDS DONATED TO THE SCHOOLS ARE UNRESTRICTED AND MAY BE USED FOR ANY PURPOSE. What a contrast this makes to those areas in which the Federal Government lends its helping hand.

What is our goal this year? One million dollars from the A.M.E.F. (that's you, doctor) and a total of \$5,000,000 from the combined efforts of the National Foundation for Medical Education (which handles the lay contributions).

Why not encourage your Alumni Association to make its contribution through the A.M.E.F. with the association receiving full credit and the school getting all "earmarked" funds PLUS THE AMOUNTS THAT WILL BE CONTRIBUTED BY THE FOUNDATION TO EACH SCHOOL?

LET'S PUT MARYLAND IN THE LEAD WITH AN "EVERYMAN" CONTRIBUTION. THIS FOUNDATION IS A GREAT WORK AND HAS WON THE WHOLE HEARTED SUPPORT OF SUCH MEN AS DR. HARVEY B. STONE, WHO IS VICE-PRESIDENT OF THE FOUNDATION.

SEND THIS TAX-DEDUCTIBLE CONTRIBUTION either to your County representative or the Medical and Chirurgical Faculty made out to A.M.E.F. If you care to " earmark " it, make the notation on your check. You will receive a receipt acknowledging this from the A.M.E.F. as well as your school.

The members of the Committee to Cooperate with American Medical Education Foundation are as follows: Doctors—Newland E. Day, *Chairman*, Thurston R. Adams, Walter E. Baetjer, J. H. Bates, Stuart Christhlf, Jr., H. V. Davis, Charles R. Foutz, J. Stanley Grabill, William B. Hagan, W. H. Sprecher, L. A. Hoffman, Philip A. Insley, Ernest F. Poole, Theodore R. Shrop.

SUMMER HOURS FOR THE FACULTY BUILDING

June 16, 1952 to October 1, 1952

Monday through Friday—9 a.m. to 5 p.m.

Saturday—9 a.m. to 1 p.m.

COMMITTEE ON INDUSTRIAL HEALTH

N. B. HERMAN, M.D., *Chairman*

OCCUPATIONAL DISEASES

An amendment to the Maryland Occupational Disease Law, effective June 1, 1951, made all diseases contracted as a result of and in the course of employment compensable. Previously, only the diseases specifically listed in a schedule were compensable.

Most, if not all, occupational diseases are preventable through the cooperation of the physicians, industries and the health department. Recognizing this requires the physician attending or called in to treat a patient whom he *believes* to be suffering from an ailment or disease contracted as a result of the nature of employment to report the case to the State Health Department, or to the Baltimore City Health Department. The post card used for report-

ing communicable diseases is also used for reporting occupational diseases.

Of 202 cases occurring in Baltimore that were awarded compensation for occupational diseases during 1950, only 4 were reported by the attending physicians to the City Health Department.

The Health Department can discharge its part of the cooperative responsibility in preventing occupational diseases most effectively when the physician attending a case that he *believes* to be related to the patient's occupation reports promptly.

It is believed that this should be of interest to the practicing physicians of Maryland since, according to statistics compiled by American Medical Association, between 80-90% of cases of Occupational Disease are first seen by the family physician.

COMMITTEE ON PUBLIC MEDICAL EDUCATION

Baltimore City Medical Society

Capital Capsules

H. HANFORD HOPKINS, M.D.

February 2, 1952

Take a letter

Commissioner of Internal Revenue, John B. Dunlap, wrote a letter to 52,000,000 tax payers this month telling them how to make out their income tax. It was typed in blue, and in large letters said, "Please read this carefully." Here are some interesting facts concerning this letter:

1. 52,000,000 copies cost the tax payer \$107,500.
2. 12,000,000 were printed by the Government Printing Office. 40,000,000 were farmed out to job printers.
3. \$107,500 represents the Federal income tax paid by 725 wage earners who make \$3,500 a year and support a wife and two children.
4. The letter was unnecessary because also en-

closed with the tax forms was a 12 page pamphlet entitled, "How to Prepare Your U. S. Income Tax for 1951."

Mr. Truman is as confused as you and I are.

Press conference Dec. 18, 1946: Mr. Truman was asked if he were urging the Nationalist Government of China to accept Communists in the Cabinet. He replied this had been set out in his statement on China. It has, he added, been our policy all along.

Press conference March 11, 1948: President Truman was asked again if it is "still the policy of this government to include Chinese Communists in the Chinese government." Truman said he didn't know that was ever the policy of the government and added, if it was it was news to him.

The difference between war and a police action.

Korean casualties from June 25, 1950 to Jan. 1, 1952 (18 months) 105,000.

World War II Pacific area casualties from Dec. 7, 1941 to Nov. 1, 1943 (23 months) 65,405.

In 1943 military victory was in sight.

February 11, 1952

National Defense Secretary Robert A. Lovett appeared before the armed services subcommittee of the Appropriations Committee Feb. 4th. He presented the 52 billion dollar budget for 1952-53 fiscal year which is supposed to take care of our defense in case more police actions break out.

Senator Homer Ferguson of Michigan asked the Secretary how much the Korean war had cost the taxpayers so far, to which Mr. Lovett replied that they hadn't been able to estimate it yet.

Senator Ferguson put another question to the Secretary: If you can't estimate a war which has been going on for the last 19 months, how can you hope to estimate the cost of a war which hasn't even started.

Chairman of the subcommittee, Senator Joseph C. O'Mahoney of Wyoming decided to adjourn.

A friend in a high place.

There will be a senatorial investigation into the 1,800 pardoned criminals President Truman has been responsible for since he has been in office. If you write to Mr. Daniel M. Lyons, pardon attorney for the Justice Department, he will tell you that there have been 5,000 criminal pardons in the past 18 years, but he will also tell you that all names and information are secret.

What your children learn in school.

Some exceptionally startling testimony in the McCarran hearings on the Institute of Pacific Relations (IPR) can be found in volume 4, pages 957 to 963. This testimony reveals that the IPR published pamphlet textbooks which were used in our schools. This branch of the Institute was in charge of Marguerite Stewart. The counsel for the committee mentioned the fact that Marguerite Stewart is the wife of Maxwell S. Stewart. Maxwell S. Stewart, he said, had been named in previous testimony as being a member of the Communist Party. Excerpts from one of these pamphlets used in our

schools as read to the committee showed Russia in a most favorable light.

February 18, 1952

Political expediency vs. U. S. honor.

The big stumbling block in the truce talks is the exchange of prisoners. The American forces have been dropping leaflets over enemy lines offering complete protection to any Red soldiers who surrendered. Thousands have poured across no-man's land bearing the leaflets. Some, relying on the American promise had the letters "U. N." tattooed on their arms while in camp.

Last week Dean Acheson and Gen. Omar Bradley briefed the Senate Armed Services Committee on the progress of the cease-fire talks. Some Senators gathered that we were willing to give up the prisoners who did not want to return, in spite of our pledges to them.

Sen. Jenner of Indiana, prepared a resolution declaring that it was the "sense of the Senate" that prisoners who did not want to return to their homeland should not be forced to; 25 senators endorsed the resolution. When word leaked to the Pentagon, Secretary of Defense Robert Lovett and Gen. Bradley immediately contacted influential Republicans warning them that such a resolution would interfere with the truce talks.

The Senators became alarmed that in an election year they might be called "warmongers," and a majority of the signers withdrew their names.

If these prisoners who trusted our leaflets promising security are returned to the enemy, the word will spread, and never again will enemy soldiers wishing to desert the Red forces trust the word of the United States government.

You haven't paid anything yet:

In case of an all-out war with Russia the estimated cost is one trillion, five hundred and seventy-five billion dollars. That is more than 30 times the \$52 billion defense budget for the coming fiscal year. It would mean that your taxes would be about 20 times more than you will pay next year.

And in case you are worried.

The army purchased enough spare parts for jeeps to last 104 years.

Quote of the week.

We are closer to peace now than we have been in the last five years.

HARRY S. TRUMAN, June 1, 1950

February 25, 1952

How to waste money and make the U. S. look silly too.

The State Department has presented Congress with a \$170 million budget for the Voice of America. The radio log of "The Voice" for January and February of this year shows the following broadcasts:

To Japan: "Feature, Jan. 22, 4:30 to 5—Children and TV." In the whole of Japan there is not a single television station or set.

To Germany and Russia: "Jan. 29—The Supreme Court decision on Judy Coplan." This was broadcast for "breakfast" and evening.

To England: "Feb. 5, 8 to 8:30—American housewives discuss pie baking." British housewives do not have the necessary sugar to bake pies.

To Arabia: "Jan. 12, 2 to 2:30—Happiness and marriage." Arabian girls marry at a tender age and their husbands may have four wives. According to Koran law a man divorces a wife by rejecting her three times before witnesses.

To Korea: "Jan. 19, 5:30 to 6—U. S. in Review, The snowbound train in the Sierras." The uncom-

fortable plight of the passengers could hardly have aroused sympathy from the war torn Koreans.

To Italy: "Jan. 14, 12:15 to 12:30—Weather forecast for N. Y. in 1952."

From the Cover of the Book, "Solution in Asia" by Owen Lattimore:

"He shows that all the Asiatic peoples are more interested in actual democratic practices, such as the ones they can see in action across the Russian border, than they are in the fine theories of the Anglo-Saxon democracies which come coupled with ruthless imperialism . . . He inclines to support the American newspapermen who report that the only real democracy in China is found in the Communist areas."

Where go the planes?

From Time, Feb. 4, 1952: Assistant Secretary of the Navy for Air, Jack Floberg said, "The situation is so bad that the Navy has 1000 planes fewer than it did 20 months ago when the Korean war began."

Quote of the week.

The people of every country are the only safe guardians of their own rights and are the only instruments which can be used for their destruction.

THOMAS JEFFERSON

CANCER SECTION OF THE BALTIMORE CITY MEDICAL SOCIETY NEWLY ESTABLISHED

At a meeting of the Baltimore City Medical Society on Friday, April 18, 1952, the formation and official recognition of a Cancer Section was ratified. The purpose of this Cancer Section will be to facilitate an exchange of ideas as freely as possible. Interested clinicians and investigators from the University of Maryland Hospital and School of Medicine, The Johns Hopkins Hospital and School of Medicine, the U. S. Public Health Service Hospital and the National Cancer Institute have held several seminars this year to initiate the local cross-fertilization of information in the field of cancer. Members of the Baltimore City Medical Society sponsoring this new Cancer Section are as follows:

Dr. Jacob Colsky

Dr. Louis E. Goodman

Dr. David M. Gould

Dr. Mitchell H. Miller

Dr. Arthur G. Siwinski

Dr. Edwin H. Stewart, Jr.

Dr. George A. Stewart

Dr. Grant E. Ward

Dr. Edward F. Lewison was elected Chairman and Dr. Robert Cooley was elected Secretary of the Cancer Section.

The next meeting is to be held at the National Institute of Health, Bethesda, Maryland, and the program is being arranged by Dr. John R. Heller, Director of the National Cancer Institute. The date and program will be announced later.

Scientific Papers

PANEL DISCUSSION: THYROID¹

The Baltimore City Medical Society held a Panel Discussion on Thyroid, on Friday, January 18, 1952, at 8:30 p.m., at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland, with Dr. Samuel McLanahan, President, presiding and Dr. Edward Rose as Moderator.

EDWARD ROSE, M.D.,² *Moderator*

Disorders of the thyroid gland are of particular interest and importance to physicians in a number of areas of medical practice. These disorders are of concern to the internist, to the surgeon, to the clinical pathologist, to the pediatrician, to the endocrinologist, to the neuropsychiatrist, and last but certainly by no means least, they are of paramount importance to the general practitioner. The general practitioner and perhaps the pediatrician, I think, occupy the front line positions in the recognition of incipient, larval and atypical thyroid disease. The ultimate fate of the patient usually rests as much upon their diagnostic acumen and judgment as upon the skill of the specialist who may subsequently take charge of the therapeutic problem.

The interest in our study of thyroid disease, in our diagnosis of thyroid disorders and in our ability to treat these disorders, has been tremendously enhanced within the past decade as a result of the development and utilization of several new materials and techniques. These include, of course, the preparation in relatively pure form of thyrotropic hormone of the anterior pituitary; the development of methods for the accurate

measurement of the hormonal iodine fraction of serum, and looming large among these new methods and materials is the use of radioactive isotopes of iodine for diagnosis and treatment and development of a considerable number of so-called antithyroid compounds. As a result of these advances, we are now in a much better position to study thyroid function, to recognize atypical forms of thyroid disease, and treat the patient, than we were a decade ago. We are now almost in a position where, in many instances, we can offer the patient a choice of treatment. We can more or less tailor the treatment to fit the individual need of the patient, a state of affairs that did not exist up to ten years ago. In the past, when treating a patient with a toxic goiter we were limited to two or three procedural methods. We could either prepare for surgery hoping we would be able to prepare him safely; we could resort to external irradiation or we could fall back on the time-honored but highly ineffective method of giving stable iodine intermittently and hope the disease would eventually burn itself out.

Today the story is entirely different. Your Program Committee has selected a group of gentlemen for this panel discussion, all of whom are interested in and experienced in various phases of the problem of thyroid disease. I hope that I shall be able to function here as a kind of

¹ Presented before the Baltimore City Medical Society, Friday, January 18, 1952.

² Associate Professor of Internal Medicine and Chief of Endocrine Section, University of Pennsylvania Hospital, Philadelphia, Pennsylvania.

Clifton Fadiman before this "Information Please" group, and to try to keep the ball of discussion in the air, or keep the pot boiling so to speak. I hope questions will be liberally forthcoming from the audience and I certainly trust the entire atmosphere of the evening will be highly informal. There will be plenty of give and take and no one will hesitate to say exactly

what he thinks as long as it is printable and recordable.

In order to start the pot boiling, each member of the panel has been asked to present and discuss briefly a couple questions. I hope all of you gentlemen have your questions ready. First, I will ask Dr. Dixon if he will answer two questions.

PSYCHIATRY

WILLIAM T. DIXON, M.D.

Q. What psychic and emotional disorders most frequently simulate thyrotoxicosis?

In other words, what purely psychogenic disorders make it difficult to make a diagnosis of true thyrotoxicosis? I think that the most common of the disorders would be a psychoneurotic reaction of an anxiety type. This simulates in many ways nearly always a true thyrotoxicosis. To mention some of the similarities, there are tachycardia, increased sweating, weight loss, diarrhea, tremor, choking sensations, shortness of breath which is referred to as "globus hystericus" in old fashioned psychiatric terms. There is often a slight elevation in blood pressure. There may be vomiting and clinical findings such as very mild glycosuria. In addition, there may be an elevation of the basal metabolic rate. All these things may be found in anxiety neurosis and of course, all of them can be found in thyrotoxicosis.

The second type of psychogenic reaction, would be a depression. Very often, particularly in middle aged or elderly women, the elements of depression make it very difficult to decide whether you are dealing with thyroid disease or a purely psychogenic reaction. The insomnia, weight loss and agitation, ceaseless restless muscular activity and the attitude of depression make it a difficult diagnostic problem at times.

Another type of reaction is the hypomanic re-

action—in other words, excitement due to a mood of elation. Some people are referred to as "a hyperthyroid personality" meaning an energetic personality which, in an extreme form would lead to complaints by the patient and others around them.

Q. With what patterns of psychic aberration are thyrotoxicosis and myxedema most often associated?

In other words, when you have a given case of thyroid disease, what type of psychogenic disorder is most frequently present?

I would again say the one that is most frequently present is the psychoneurotic reaction with symptoms of marked anxiety, phobias and hysterical symptoms. There may be an associated psychotic reaction such as a manic depressive reaction. How to separate them sometimes is quite a problem. Which is thyroid disease and which is emotional illness. They are so bound up that I don't think you can separate them.

There may be a paranoid psychotic reaction where the patient is deluded, suspicious, thinks people are trying to persecute him, and finally there is a delirious type of reaction which is called a toxic delirium or delirium due to lack of support of the brain.

In myxedema I do not have as much information, but generally psychotic reactions are more prevalent when the patient is emotionally upset

and sometimes there are neurasthenic reactions—that is psychoneurotic reactions. The old term neurasthenia is associated with weakness, coldness of extremities and fatigue.

DR. ROSE: Thank you, Dr. Dixon. We are all very familiar with the occasionally very difficult problem of differential diagnosis which is posed by the highly emotional patient, the patient with symptoms which could be due either to psychic or emotional disease, or which might be the early manifestation or the atypical masking phenomena of thyrotoxicosis. Fortunately, some of the newer diagnostic methods which are now available and which I hope will be discussed with more detail this evening, come in as very

useful tools in helping us solve these occasionally very difficult problems. Several patients whom I have seen in the late, terminal stages of manic depressive psychosis, have gone into a terminal episode which has closely simulated the clinical picture of the thyroid storm or crisis. I'd like to know whether that similarity has struck you, Dr. Dixon?

DR. DIXON: Yes, I have seen it. I don't know whether they have been studied for endocrine disturbances. I suppose they have but I don't know the findings.

DR. ROSE: Thank you, Dr. Dixon. I'd like to ask Dr. Rienhoff if he will continue the discussion.

SURGERY

WILLIAM F. RIENHOFF, JR., M.D.

In answer to Dr. Rose's question I would like to say that we surgeons feel that the use of propylthiouracil combined with Lugol's solution is an excellent method of preparing patients for the surgical treatment of hyperthyroidism. I am not convinced that the use of this drug, namely, propylthiouracil should be used as a definitive measure. Some patients will improve for two years or so and then begin to escape the influence of this drug. Certainly for the average, run of the mill case of hyperthyroidism, particularly with a fairly large thyroid gland, we feel that the operative treatment is more permanent and more satisfactory for the length of time the patient must be under the guidance of a physician and a surgeon.

There are, of course, individuals who cannot take propylthiouracil, in fact, any thyroid drugs. Another objection is that patients become rebellious against the constant laboratory supervision and the necessity for always taking a drug day in and day out.

There are certain patients for whom thyroid-

ectomy is contraindicated, and for these the medicinal treatment with propylthiouracil is certainly a boon; namely, in acute hyperthyroidism following an upper respiratory infection; in the latter stages of pregnancy; in elderly patients; in hypertension associated with cardiac failure, and for patients who refuse operation.

I do not believe that once a thyroid gland has undergone hypertrophy and hyperplasia it will ever revert to the normal histological picture or the gross size of the gland when treated with propylthiouracil. People living in parts of the state or states that are inaccessible to proper laboratories have great difficulty in checking their blood counts and their metabolic rates. Furthermore, there is always the personal element of stupidity or carelessness in adhering commendably to a medical regime.

In regard to nodules in the thyroid gland, I am firmly convinced that all solitary nodules should be removed and carefully examined histologically. The instance of malignancy in these nodules varies from 15 to 25 per cent, depend-

ing on the individual clinical records. These nodules may or may not be malignant from the beginning. The danger of malignant change in multiple nodular goiters is certainly less than in the solitary nodules.

The type of operation to be done depends upon the type of tumor. The intracystic papillary adenocarcinomas, of course, are very slow-growing and metastasize only to the lymph nodes; therefore, the glands should be removed with the thyroid, bilaterally. The malignant adenoma, however, does not spread by the lymph stream and it is necessary to remove only a portion of a lobe, and not a radical lymph node dissection of the neck.

In regard to cardiac arrhythmias associated with multiple nodular goiters, I feel that the thyroid should be removed before the arrhythmia has been in existence.

Q. DR. ROSE: What about the second question, Dr. Rienhoff, the needle biopsy?

DR. RIENHOFF: Oh, yes. I forgot that one. I can only remember needle biopsy to condemn it. In the first place the thyroid gland, as all surgeons know, is a gland in a state of flux. It is a gland that presents a different histological picture on either side. Whenever you put a needle in the thyroid gland, you do not know whether or not you're going to put it in a large vein; you don't know that the biopsy specimen you get through a needle is going to be representative of the gland as a whole. I feel that if I were the patient, I'd much rather have the surgeon explore my neck and see what he's got before him, rather than do a needle biopsy. Biopsy might not be representative of the pathological picture of the gland as a whole. I am against needle biopsies; if it is carcinoma it may be spread through the needle puncture, as has been done in lungs; or if you happen to hit an area that is benign, how in the world can you tell what exists in the remainder of the gland, particularly intracystic papillary adenocarcinomas.

Dr. Firor, sitting back there, was talking the other day at a conference, saying that sometimes

one sees glands in the neck or the patients feel them. You remove one of these glands, you look at it in the gross, and you can be pretty sure that it isn't a lymph gland. It looks like thyroid tissue so therefore you know in all probability, and particularly with the information of the frozen section, that there is a tumor in that lobe probably on that side. Now I feel very strongly about this situation. I think you should do a double partial lobectomy, a removal of both lobes, because we have seen that these tumors will occur bilaterally. Dr. Blalock had that experience, and I've had it three times. Dr. John Pemberton, at the Mayo Clinic, found that you often have a small tumor not any larger than a small pea, which will metastasize in the gland and will be quite large (two centimeters by one and a half centimeters) so I feel that if you did a biopsy and happened to hit the normal part of that lobe, you'd say, therefore, Dr. Rose, that this is not malignant. You would be misled; and I don't like needle biopsies anyway.

DR. ROSE: The chief proponent of needle biopsy of the thyroid at present seems to be Dr. George Crile, Jr., of the Cleveland Clinic. I believe that he considers it tremendously useful in detecting certain types of chronic thyroiditis, in which surgical treatment is either not indicated or only a conservative partial measure late in the disease in such types of thyroiditis as the struma lymphomatosa or the Hashimoto goiter. I know that a number of other thyroid surgeons do not share Dr. Crile's enthusiasm for this procedure. I have discussed it recently with Dr. Ravdin and I think he substantially shares your own views, Dr. Rienhoff. The problem of multinodular goiter is an extremely knotty one as I am sure you all realize from what Dr. Rienhoff said. Even the problem of the so-called solitary nodule is not always so simple because I think we must bear in mind constantly that the portion of the thyroid gland that one may see or feel does not by any means always indicate the true size, location and shape of the entire thyroid gland. Frequently we think we are dealing with

a solitary nodule and when the gland is exposed to view by the surgeon, frequently a number of other nodules are found hidden away beyond the reach of the palpating finger.

One of the difficult questions is, when is a solitary nodule really a solitary nodule? Various arguments have been advanced in recent years in support of the idea that the multinodular nontoxic goiter should be treated conservatively. The arguments have included the statement that the incidence of carcinoma in the multinodular goiter is so low that the operative risk of removing the goiter is greater than the risk of malignancy if you leave it alone. Such a statement

seems to reflect a little bit on the surgical mortality of the institutions which had been used in the collection of statistics. Other claims are to the effect that if you operate on a multinodular goiter you have either got to do a total thyroidectomy or nothing at all; if you do a subtotal thyroidectomy you may leave behind certain microscopic foci from which regenerative changes may lead to the development of new adenomata and possibly carcinoma may develop when none was present at the time of the original operation. These are some of the controversial points that are tremendously difficult to settle.

DR. ROSE: Dr. Carey, would you present your question please?

INTERNAL MEDICINE

T. NELSON CAREY, M.D.

Q. For his first question Dr. Rose asks me what are the indications for the use of stable iodine in the prevention and treatment of thyroid disorders.

The most fundamental use of stable iodine in thyroid disease is for the prevention of endemic goiter, which we do not see in this part of the country. The basic research on this problem was done thirty years ago or more, and you will remember that it refers to the prophylaxis, in the mass of the population, of the thyroid enlargement that appears so frequently in the "goiter belt" or glacial parts of the United States, in the Alps, and in mountainous districts elsewhere in the world.

It is interesting to all of us that the dose of iodine used for this purpose is almost fantastically small, somewhere between 70 and 150 micrograms daily. This may be supplied by the routine use of iodized salt containing less than one part of sodium iodide per 5,000 parts of sodium chloride.

In the treatment of endemic goiter once it has

developed, larger doses are necessary, but they are still amazingly small. It has been suggested that one milligram of potassium iodide weekly, in addition to the prophylactic dose, may be entirely satisfactory, if the goiter is reversible and has not passed the period of hyperplasia which can be returned to normal by the use of iodine. There are other variants of this type of goiter. One of them was discovered in Dr. Chesney's laboratory some twenty-five years ago. Rabbits that were fed on a cabbage diet developed thyroid enlargement, and the term "cabbage goiter" has been applied to this phenomenon. Some human cases have been described. As the disease is caused by relative iodine deficiency, it may be prevented or treated by increasing the iodine intake.

More recently, stable iodine has become very important in the prevention of the hyperplasia and bleeding tendency caused by the antithyroid drugs. When the antithyroid drugs were first introduced, iodine was only given during the last week or ten days of preparation for opera-

tion, but later on it was discovered that iodine could be used at the onset of antithyroid drug therapy. The surgeons found that glands treated in this manner were much less frequently a source of bleeding and that hyperplasia was far less troublesome.

The next use of stable iodine that we should discuss is the standard method of production of the iodine remission in hyperthyroidism. This method of preparation for operation is still used at times. The dose of iodine necessary to cause remission was studied many years ago, particularly by Means and his group. Again, the dose is quite small, and where we are all accustomed to giving twenty or thirty drops of Lugol's solution or solution of potassium iodide daily to cause the preoperative remission of hyperthyroidism, it has been convincingly demonstrated that only six milligrams of iodine is actually necessary. According to Dr. Mean's calculations, this represents only one drop of Lugol's solution daily. Actually, however, since iodine is not expensive and since there is no reason for stinginess in dosage, I believe that no one limits himself to this small quantity.

The next important use of stable iodine is in the emergency management of the unexpected crisis. Postoperative thyroid storm has almost completely disappeared, but occasionally because of unjustified use of iodine in toxic goiter and its sudden withdrawal, crises may appear. The critical patient is entirely too ill to depend on the relatively slow action of the antithyroid drugs or radioactive iodine, though he can, under certain conditions, be helped very dramatically by the administration of stable iodine in large quantities by whatever method it can be given, along with other therapeutic measures, such as sedatives, oxygen, and fluids.

This is an extremely short and, I hope, not oversimplified description of the uses of stable iodine in the management of thyroid disease generally. I am quite sure that I have neglected some important facets of the problem, and I hope that I will be forgiven if I have done so.

Q. The next question is far more difficult to answer, and I do not believe that it has ever been satisfactorily solved. Dr. Rose asks me to discuss the optimal therapeutic program for the hyperophthalmopathic syndrome.

The patient with this problem has, in addition to moderate or marked exophthalmous, stare, lid lag and the other eye signs associated with hyperthyroidism, excessive lacrymation, burning and stinging of the eyes, edema of the conjunctivae, and occasionally, inability to close the eyes completely. It is interesting that the clinical picture is as often seen in the mildly hyperthyroid individual, as it is in the patient with severe toxic goiter.

Treatment of this complication should be based chiefly on the principle of not making it worse. It is known that overtreatment of hyperthyroidism can lead to further production of the thyrotropic pituitary hormone with further exaggeration of exophthalmos. The rule should be, I suppose, that thyroidectomy should be undertaken with the greatest of caution, whether that thyroidectomy is surgical with the knife, medical with the antithyroid drugs, or radioactive with I^{131} . Much work has been done on the problem, and some investigators believe that the prolonged conservative treatment with rest and sedatives may be the method of choice, hoping that the hyperthyroidism may subside without the exophthalmos becoming more troublesome.

Other methods have been tried. Thyroid has been administered when basal metabolic rate is not too much elevated, or when progressive exophthalmos appears postoperatively, in an effort to suppress the production of the thyrotropic hormone. Radiation of the orbits, radiation of the pituitary gland, and more recently adrenocorticotrophic hormone have been tried. None of these measures have proven to be satisfactory. The last resort is surgical decompression of the orbits, either by the frontal approach of the Naffziger operation or the more recently devised temporal method. Surgical intervention is usually reserved for those individuals whose sight is in

danger and is not recommended for cosmetic reasons.

DR. ROSE: Thank you, Dr. Carey. I see so constantly so many glaring examples of the misuse and abuse of stable iodine, especially in the treatment of thyrotoxicosis, that I was constrained to submit this question to Dr. Carey. I think it is an extremely important point. In spite of the constant factual reiteration to the medical profession that stable iodine almost always exerts only a partially ameliorating effect upon thyrotoxicosis, and that usually the effect is temporary and that after several weeks or a couple of months the patient will become iodine resistant and just as toxic and even more toxic than he was when the treatment was started, we still see numerous examples of the misuse of iodine. It isn't so much of a tragedy as it was ten or twelve years ago because we have at our disposition all the antithyroid drugs with which we can almost always bring a patient into satisfactory remission, but it is still a sore point with me in practical therapeutics.

We happen to have in our hospital at the present time, a delightful young woman, wife of a physician, who developed thyrotoxicosis last summer and whose sole treatment until she was brought to our hospital on the verge of a thyroid storm consisted of the administration of Lugol's solution by her husband. She had had no studies and that was her only therapy.

The second question which Dr. Carey answered is, as he says, a very difficult one and it was with some apology in my mind that I submitted it. Therapy of the so-called hyperophthalmopathic syndrome is almost impossible to evaluate. These patients look as though they are going to lose their eyesight; they look as though their eyeballs are going to bulge out from their cheeks, which occasionally they do. Yet even in their most formidable stage where catastrophe seems inevitable, the whole process may cease spontaneously and the acute congestive and inflammatory phenomena may begin to re-

cede. The patient may regain practically normal vision after being almost blind. This can happen spontaneously and when it does happen after one or a number of therapeutic agents have been employed, it is obvious we are in no position to draw conclusions regarding the effectiveness of our treatment.

I might mention the recent enthusiastic reports that arrived in this country from France about a year ago concerning the alleged inhibitory action of a compound called para-hydroxy-propiopnone upon certain hormonal production of the anterior pituitary. This substance which in essence when you look upon its structural formula, looks about like one half diethylstilbestrol molecule, was claimed by French physiologists and clinicians to be capable of inhibiting the thyrotropic and gonadotropic hormones of the anterior pituitary without affecting the adrenocorticotrophic output. These claims, if true, would have been sensational and therapeutically revolutionary and a lot of people over here immediately got busy in an effort to support the French claims. The French reported several hundred patients with thyrotoxicosis with and without associated ophthalmopathic phenomena having been treated very successfully, and patients with various disturbances associated with increased output of gonadotropins also having been treated successfully.

The experiences both in the laboratory and in the clinic in this country with this compound as far as I have been able to learn, including our own clinical use of the drug, have been almost completely disappointing. We have treated a number of patients with hypothyroidism, ophthalmopathy, diabetes, some patients with menopause and menopausal syndrome, and we have not seen any real evidence that it has been or has produced any effect other than that which might have been due to suggestion to the patient.

Would you present your questions please, Dr. Berthrong?

PATHOLOGY

MORGAN BERTHRONG, M.D.

Q. The first question is: What is a Hürthle cell? I might say at the beginning that it is unfortunate that we have such a name in the pathological literature. In the first place it is a misnomer. Hürthle originally described a large eosinophilic cell in the interstitial tissues of the thyroid gland of a puppy dog. Whether or not these same cells ever occur in humans is still a question. Furthermore, these cells were described in the human thyroid years before Hürthle made his observations in the dog.

In any case, the so-called "Hürthle" cell is a large eosinophilic cell which occurs in the thyroid in a large number of abnormal conditions. It seems to be quite nonspecific. It may occur in neoplasms or non-neoplastic diseases. In the former it may constitute the sole neoplastic cell; at other times only a portion of the neoplasm is made up of these cells. The Hürthle cell is quite commonly seen in non-neoplastic thyroid diseases and is especially prominent in Hashimoto's struma. They are also seen in Riedel's struma but far less prominently. They were described very early as a prominent cellular change in hyperplastic thyroids. I think I can summarize by saying that the Hürthle cell probably represents a metaplastic change of normal thyroid epithelium during a wide variety of disorders of the thyroid. Hürthle cells are not specifically related to any functional change, as far as I know. I would like to add that similar cellular changes occur in many other organs as in the salivary glands, mucous glands of the upper respiratory tract, in the gall bladder, and others.

My second question was somewhat introduced by Dr. Rienhoff who suggested that I might talk about thyroid cancer, nodular goiter, solitary nodule, etc. He reminds me of my brother who used to lead me up on the top of the high diving board and I'd look down from the end of the board at the water a mile below, and he'd say "jump, you coward, jump!" I'm not going to

take that bait entirely, but the question that I do have is:

Q. What proportion of nodular goiters represent true adenomas?

I don't know the exact figures but I am certain, Dr. Rose, that of all the nodules that occur in the thyroid glands of people both in endemic and non-endemic area, both macroscopic—that is palpable nodules,—as well as microscopic nodules, that the vast majority are not true neoplasms. They probably represent some result of abnormal function which, throughout the years at different levels of physiological activities with alternate periods of hyperplasia and involution, has led to the development of nodular masses in the thyroid. True adenomas are certainly very rare in comparison to these non-neoplastic nodules.

Finally, Dr. Rose, you have asked me what the relationship is between true adenomas and thyroid cancer?

My first words will be that I don't know. Second, I don't think it is clearly known anywhere. We have many references which give figures of eighty to eighty-five per cent of all cancer in the thyroid arising in benign adenomas. In our own end of the scale we had fifty-five carcinomas of the thyroid in a period of ten years, one of which a pathologist suggested probably arose in an adenoma. The problem for pathologists to say that a benign adenoma was originally benign and became malignant, or was always malignant, is so great that there can be no clear-cut answer to this question. The very long clinical duration of this type of thyroid cancer greatly complicates our precise understanding of the question. We see adenomas of the thyroid which have in every way a histological appearance which is utterly benign and yet we have metastasis in the bone, lung, etc. On the other hand, we see nodules in the thyroid which appear histologically malignant that had

no evidence over a period of many years of any clinical malignancy. Some may show metastasis after 20 or 25 years while others with the same histological appearance may pursue a far more rapid course. It does seem probable that given a patient with a solitary nodule in the thyroid, especially in children, young adults or men, the pathological examination is much more apt to show a true tumor, either an apparently benign adenoma, an adenoma with evidence of early malignant changes, or an overt cancer, than is the case if diffusely nodular glands are so examined.

DR. ROSE: I submitted a question about the Hürthle cell because many of you gentlemen are going to receive from time to time reports from the pathologists describing the histological appearance of thyroid tissue removed from some of your patients, in which this term protocoel will appear. As Dr. Berthrong pointed out, the nature of the cell, and function, if any, is controversial. I think the majority of opinion at the present time inclines to the view it does not represent a specific cell type in the thyroid, but may represent a transitory functional phase of several types of cell which take on the characteristic eosinophilic stain and which may be found under different circumstances and in different parts of the thyroid structural units.

I submitted the second question because this whole problem of being conscious of the pre-malignant lesion in the thyroid is an extremely important one. All of us who work in thyroid clinics are constantly encountering examples of neglected thyroid cancer in which life could have been saved by the exercise of good clinical judgment at some time in the patient's past history.

Q. DR. RIENHOFF, you did some pioneer work some twenty-five years or so ago on the pathogenesis of thyroid nodules and the incidence of true adenomas and so-called colloid hyperinvolution nodules in goiter. Would you care to comment on anything Dr. Berthrong said?

DR. RIENHOFF: A number of years ago when Dr. Arthur Bloomfield was here and after Dr. Plummer brought in the iodine treatment, I

think it was in 1922 or 1923, we found there were artificial remissions due to the administration of Lugol's solution and with the permission of Dr. Finney, Sr., I biopsied the thyroid gland before and after giving iodine. We found even in the artificial iodine remission, there were areas which underwent hyperinvolution which not only returned approximately to the normal status of the normal gland but overdid it. It was somewhat like an emphysematous lung. Follicles would dilate and form large cysts through the gland and some areas would show localized hyperplasia, which Dr. McCallum first called attention to, and which would persist. These could even be palpated in the gross. Now the question is what is the character of these nodules. We have often seen the step-up goiter of pregnancy following the physiological hypertrophies and hyperplasias due to pregnancy, and undergoing involution.

People in goiter districts in which for some reason or other these processes such as hypertrophies and hyperplasias as well as involution are exaggerated may appear with nodular goiters. They can even tell you "this nodule appeared after such and such a child was born." They are usually in the mountainous districts. We decided that very few of the nodules really—and that was with fairly good pathological supervision, could be considered benign tumors; that most of them were coals of the fire that had burned and they were probably physiological residues. I was very much interested in a discussion Dr. Trimble made the other day. He stated that if you are going to remove the lobe of a gland because of multiple nodules, where are you going to stop because you will probably find they are multinodular glands. Nodules will be found not only in one lobe but you will find them in others probably. It is a very controversial question; are you really operating on neoplasm or multiple neoplasia, or are you operating on physiological residues?

DR. ROSE: Dr. Asper has a couple questions which are quite active and of current interest.

RADIOACTIVE IODINE

SAMUEL P. ASPER, JR., M.D.

Radioactive iodine is assuming a role in the diagnosis and therapy of certain thyroid disorders and is still in a process of development. So far, it probably has reached its highest development as a tracer test or a diagnostic test for the determination of the state of function of the thyroid gland. I am sure that the next few years will see considerable revision in this procedure which will make it available for use in most all clinics. One must remember, however, that the test as now used measures only the thyroid's avidity for iodine and does not therefore reflect the rate of function of the thyroid gland. Like the BMR, it does not give an exact interpretation of thyroid function. It is therefore not only dependent on the activity of the thyroid gland and the rate at which thyroid hormone is formed but also on the supply of iodine which the patient has been receiving.

The radioiodine tracer test has considerable clinical value chiefly because of its accuracy. Probably it is best used in rather difficult thyroid cases. In patients Dr. Dixon described, having psychiatric abnormalities and in whom the diagnosis of hyperthyroidism is questioned, the administration of a tracer dose of radioiodine oftentimes will establish whether or not the thyroid gland is hyperfunctioning. In such patients the basal metabolic rate would not be feasible. It does not supplant the basal metabolic rate nor does it supplant the protein bound iodine determination.

One must also remember that radioiodine tracer tests have no value in patients who have received large doses of iodine in any form. A patient who has received Lugol's solution prior to coming to the laboratory for a radioiodine tracer test will have no accumulation of the radioactivity in the thyroid gland because of the previous saturation of the body with excess iodine. The same is true for iodine administered as an x-ray dye or for some vitamin preparations which now

also include iodine. Also desiccated thyroid or thiouracil and other antithyroid drugs, will affect the test during their administration. It is necessary, therefore, to remove the patient from desiccated thyroid or thiouracil or the iodine preparation for a considerable period before the radioiodine tracer test is of clinical value.

When it comes to selecting patients for therapy with radioactive iodine, which is the second part of the question Dr. Rose submitted, we are at the present time in a state of flux. In our clinic patients who are treated with radioactive iodine are patients not suitable for other standard forms of treatment, and in general they are complicated thyroid cases. But it is most amazing to us that, despite the fact these patients have complicated disease, the results are exceptionally good. It may be with further experience that radioiodine will be used more extensively. It already is used in some clinics for the treatment of Graves' Disease. In these patients, the radioactive iodine is given by mouth. The difficult part of the therapy is to calculate the dose; generally, it is between five and ten millicuries. It is repeated after two or three months if hyperthyroidism still persists, usually at a somewhat smaller dose. It may be necessary in some patients, especially those with nodular goiter, to give several doses before the disease is ameliorated.

It has its especial advantages in older patients who are not suitable candidates for surgery. The most suitable example for the use of radioiodine that one could hope for occurred recently in a patient who came to the hospital with severe hyperthyroidism. She was elderly and had auricular fibrillation and cardiac failure. She had been sensitive to propylthiouracil, thiouracil and Lugol's solution. She was too sick to consider subtotal thyroidectomy. She received radioactive iodine and had a complete recovery. One might ask, "Why could she take radioactive iodine and

not have a reaction when she had been sensitive to Lugol's solution?" The amount of iodine contained in a therapeutic dose of radioactive iodine is an infinitesimal amount of iodine, and would be equivalent to the amount occurring in about a teaspoonful of Baltimore tap water. Knowing that she was not sensitive to the iodine contained in tap water, one could give her without hesitation radioactive iodine.

DR. ROSE: Thank you, Dr. Asper. The final mapping of the usefulness, limitations, possible dangers and undesirable or late sequelae of radioactive iodine will certainly not be completed for a number of years. I think there can be no doubt

that it offers us a very powerful therapeutic weapon, but it will take some time before we are in a position to use it with complete intelligence. Until that time comes I think it should properly be looked upon as a method of treatment still in an exploratory phase. Its use is as a therapeutic agent in the treatment of thyrotoxicosis in children or with certain occasional exceptions in young adults; we avoid its use in pregnant women and are attempting insofar as we can to limit it to middle aged or elderly patients.

Now we have several questions from the audience and I'm going to ask Dr. Fort if he will read them.

QUESTION AND ANSWER PERIOD

Q. Please give a clear-cut statement on the indications for the use of thyroid extract and a practical method for control of the dose?

DR. ROSE: I think this is a very important question because along with stable iodine (in the form of Lugol's solution), potassium iodide and other pharmacopeial preparations, desiccated thyroid is one of the most misused and abused drugs in the entire United States. I'm going to ask Dr. Carey if he will undertake to answer that question.

DR. CAREY: I certainly agree with Dr. Rose in his statement that thyroid is misused many, many times, and I believe that its chief misuse is in the attempted reduction of obesity. You will remember that the obese person has excess heat production to start with. This is a wonderful safety factor that the body has developed to keep us all from becoming tremendously obese. As weight gain appears the basal metabolic rate rises. If this were not so, with a little bit of extra food every day any individual would in a relatively short time become tremendously obese. Therefore, it is sensible to believe that if the obese person has an elevated basal metabolic rate to start with, administration of thyroid by

mouth is not the proper method of reducing weight. The proper method to reduce weight is, of course, by diet, and by diet we should mean undernutrition for the person's ideal weight. This method, if carried out, predicts weight reduction most accurately. Many times the emaciated person will be given thyroid because the basal metabolic rate is low. There again, is an example of the same principle. As the body loses weight the basal metabolic rate falls, heat production declines as a safety factor, and the body protects itself from wasting away altogether. Along with weight loss, basal metabolic rate falls, vital functions also are preserved, sexual potency disappears, menstruation stops, and gynecomastia develops in the male. This was all demonstrated very vividly in prison camps during the recent war. Therefore, it is sensible to believe that a starved person whose basal metabolic rate is as low as minus 25 per cent certainly does not require thyroid to gain weight, but simply requires food. I believe that these are the two most glaring examples of the misuse of desiccated thyroid. Proper use, of course, is in true thyroid deficiency which is most commonly seen after operation for hyperthyroidism or total thyroidectomy either

intentional or unintentional. In that case we have a true state of myxedema which requires a surprisingly small amount of desiccated thyroid for correction. It is important to remember that the myxedematous person is quite sensitive to this material, and that the average patient requires about 100 milligrams daily, about one and one-half grains. A larger dose is very commonly associated with toxic symptoms. The drug should be used carefully with guiding estimations of weight, heart rate, basal metabolic rate, blood cholesterol estimation, and observation of response of symptomatology.

DR. ROSE: Thank you, Dr. Carey. Would you read the next question?

Q. This question is addressed to Dr. Rose. A patient had been taking thyroid pills, three grains a day for years. You expect from her description of her original symptoms that she did not have hypothyroidism at that time and should not have been started on thyroid. Are there any investigative procedures to test your contention after the patient's daily intake of thyroid is discontinued? How long will it take for her own thyroid hormone production to help turn to normal, and shall her intake of thyroid hormone be stopped at once or gradually?

DR. ROSE: This is a very common clinical problem. I should like to call your attention to a very interesting and useful article which appeared in the November 1951 issue of the *Annals of Internal Medicine*, by Johnson, Squires and Farquharson, of Toronto, dealing with the physiological effects of the administration of desiccated thyroid to persons with normal endogenous thyroid function. In reply to this specific question I would say that any attempt to evaluate the patient's own endogenous thyroid function while she was still taking three grains of desiccated thyroid daily, would be fruitless because of the distorting effect of such prolonged therapy upon the patient's own thyroid activity and because of the misleading changes in serum precipitable iodine and in metabolic rate and in the capacity of the patient's own thyroid to take up

traces of radioactive iodine. The only way to find out whether that woman really has hypothyroidism or not would be to withdraw the desiccated thyroid and when she has been without any of the drug at all for a period of two months then to study her thyroid function by the currently accepted methods. The time required for the patient's thyroid to regain its maximal pretreatment endogenous function varies considerably. According to some studies reported last year in the *New England Journal of Medicine*, by Greer, of Boston, based on recapture of normal ability to take up radioactive iodine, such normal ability may be regained in periods of time varying from two weeks of time up to eleven weeks after the cessation of thyroid medication. Of course it depends upon radioactive iodine uptake, as the major measure of thyroid self-function might not have been justifiable. It may require then as long as eleven weeks occasionally, even longer for a patient's own gland to bounce back, so to speak. The work reported by the Toronto group, however, suggests that even after years of thyroid feeding to a person not originally hypothyroid, that person's own thyroid gland can come back despite many years of suppressive effect exerted by thyroid therapy. So that to boil the thing down I'd say to study the patient's thyroid function while she is still taking thyroid would be useless. You should withdraw the thyroid and after a period of about two months then you can study the patient's thyroid function with some hope of learning the truth. The third part of the question, e.g., "should the thyroid be stopped abruptly or gradually." I think it is a pretty good general principle in endocrine therapy when you stop medication, (unless it must be stopped abruptly to avoid catastrophe), to do so gradually and you are less likely to precipitate an acute dislocation of endocrine interrelationships which may lead to very undesirable consequences. I'd suggest in this particular case cutting down gradually, putting the patient on two grains a day for a week and then one grain a day for a week and then a

grain every other day and tapering it off for three or four weeks. Wait two months and then study your patient's thyroid function.

Q. This question is addressed to Dr. Dixon. May the basal metabolic rate be elevated in anxiety states further complicating the differential diagnosis?

DR. DIXON: I mentioned that as a factor in anxiety neurosis the basal metabolic rate may be elevated. It usually isn't extremely elevated but it can be enough so as to make it a difficulty in establishing a definite diagnosis of thyroid disease. I had hoped for a chance to make a comment on the BMR from the point of view of the psychiatrist in practice. He sees many patients, who have been influenced by BMR findings. I feel that it certainly has been overemphasized and I am sure you will agree. It is only one diagnostic test and it certainly isn't foolproof; it can be influenced by so many factors. I would say the answer to the question is yes, and that in a psychoneurotic reaction with enough tension, and enough physiological upset due to anxiety, that there can be an elevation of BMR.

DR. ROSE: I might point out that two modifications of technique have been reported in the past few years which increase the value of the basal metabolism determination, or rather to put it the other way around, to eliminate some of the bugs from the method. The first of these was reported a couple of years ago by Dr. Bartels of The Lahey Clinic, which consists of the determination of the basal metabolic rate while the patient is under anesthesia induced by intravenous pentothal. By performing the test under these conditions artificial elevation of the basal metabolic rate produced by emotional tension or hyperventilation can be eliminated and you get a more nearly correct picture of the patient's true basal metabolic rate. The disadvantages of this method is that it requires a team, an experienced team, an anesthetist and a basal metabolism technician who have learned to work together. The patient has to be watched, of course, very closely and the jaw has to be held up so

that the mouthpiece will not leak. We have used it in a number of situations in the past couple of years since Bartels reported it, and we have found it occasionally very useful in attempting to decide whether a given patient was really ready for thyroidectomy or not. The second modification was just reported in the December issue of the *Journal of Clinical Endocrinology* by Dr. Rappaport and Dr. George Curtis, from Columbus, Ohio. It is what they call the determination of the somnolent metabolic rate, or the SMR instead of BMR. What they do is simply to put the patient to sleep with intravenous nembutal and they carry the procedure out as an office test. The patient comes in and they give him intravenous nembutal, after he has a couple of conventional BMR determinations and then they measure his metabolic rate while he is asleep. Both of these methods will probably prove to be useful in certain selected problems.

Q. Will some member of the panel say a word against x-ray treatment of thyroid disease? (laughter)

DR. ROSE: That sounds like it came from somebody who got burned somehow or other. Dr. Asper, would you care to take up the cudgel?

DR. ASPER: It is hard to say much against what is one of the very first treatments used for hyperthyroidism and was much in vogue between 1900 and 1925, and was still used as recently as 1930 and rather extensively. There are over ten thousand cases reported in the literature of x-radiation to the thyroid gland or the implantation of radon seeds into the thyroid. It is a treatment which has not been used so much of late since surgery has been so well developed, especially since patients were prepared with Lugol solution. However, there is no question but that in certain cases it works quite satisfactorily and we have used it in a patient within the past two years with very good results. It is said that external x-radiation to the thyroid gland is more effective in a patient who has not been previously treated with Lugol's solution, another reason supporting Dr. Rose in his state-

ment that before one uses Lugol's solution one must give consideration to its possible disadvantages.

DR. ROSE: Dr. Pancoast and Dr. Eugene Pendergrass and I had a fairly considerable experience with external irradiation of the thyroid over a period of twenty years or more during which we treated approximately eight hundred patients. We were able to get in selected cases—and the word “selected” should be emphasized—we were able to get about fifty-seven per cent of satisfactory results but it required usually several months before maximum response could be observed. There were occasional late undesirable side effects, burns, etc. The method has now been almost totally abandoned insofar as thyroid irradiation of the pituitary and sometimes of the orbits employed in the treatment of the hyperophthalmopathic type of Graves' disease is concerned.

Q. How does the protein bound iodine test compare with other tests of thyroid function?

DR. ROSE: I might presume to say a word or two in reply to that question. The measurement of the so-called serum protein bound iodine or serum precipitable iodine presumably measures that fraction of the total serum iodine which is bound to or incorporated within the thyroid hormone. Nobody is yet sure just what the thyroid hormone is, most people now believe it is probably thyroxin which is loosely bound to one of the fractions of serum albumin. The accurate performance of this test requires special skill and experience on the part of a technician. It is a complicated and laborious piece of laboratory work. Contamination from many sources must be rigidly excluded. Special apparatus is required and for this reason it has not yet become widely established as a routine hospital laboratory procedure. However, it is growing steadily in popularity and it is becoming more and more widely available as a diagnostic method. A normal concentration of serum bound iodine is extremely small, and this explains in part the difficulty of getting an accurate and reliable result. The nor-

mal range varies geographically to some extent from one part of the country to another. In this part of the country it is somewhere between four and eight gamma, that is thousandths of a milligram per one hundred cc's. There is some variation also in the normal range depending on the technique which is employed. There are several methods for its measurement. It should be remembered that the results can be affected by a number of factors, the administration of desiccated thyroid, the occurrence of disease in other organ systems, pregnancy, kidney disease, congestive heart failure, adrenal cortical insufficiency, all can affect the level of the serum precipitable iodine. If the patient has been taking iodine in any form even though that iodine has been inorganic, it is possible for the serum precipitable iodine to be artificially affected. The administration of antithyroid drugs such as thiouracil compounds can affect the level of the serum precipitable iodine and the administration of mercurial diuretics can cause artificial fluctuations. The consensus of opinion reported by those who have compared this method with the reliability of tracer studies, using radioactive iodine, inclines to the view that the tracer technique is more completely reliable than measurement of the serum precipitable iodine. I think it fair to say that when properly developed and controlled, it is a very useful addition to our diagnostic armamentarium and I believe it should properly be incorporated in the laboratory facilities of every first class hospital.

Q. What is the panel's opinion of the efficacy of propylthiouracil alone in the treatment of the average case of hyperthyroidism?

DR. ROSE: This is a very timely question and I'm going to pass it along to Dr. Asper.

DR. ASPER: Dr. Rose, one of the student nurses at our hospital recently calculated that it would be possible for a patient to take maintenance doses of propylthiouracil and come to the clinic at periodic intervals for twenty-two years for what it would cost a patient to have the thyroid gland removed. (laughter) In mak-

ing such a statement we do not advocate that the prolonged use of propylthiouracil is the treatment of choice but there is no doubt that patients who have moderate hyperthyroidism and a small diffuse goiter, especially if they are young women, will have a very satisfactory response to propylthiouracil when given over a prolonged period of time. In the patients that we have in our clinic, patients who are selected only in that they are willing to take the drug over a long period of time, we have had fifty per cent of them to have what appears to be a permanent remission of the disease. However, I think that this is open to considerable question because we know that even after surgery patients come back some five and ten years later with a recurrence of hyperthyroidism. One of our patients in whom we had thought the disease had been "cured" came back three years later with recurrence of the disease. It may be that propylthiouracil is only an agent which can be used to bring about an amelioration of the disease during its administration with perhaps all patients eventually having a relapse, but so far fifty per cent of our patients seem to do quite well after a prolonged period of administration. By prolonged periods it apparently *really* means a prolonged period because it is very clear that administration of propylthiouracil for a period of six months or less will result in a remission rate of almost ninety-five per cent of the patients, but when the drug is given for a year or longer, then the remission rate is about fifty per cent.

DR. ROSE: The use of these antithyroid compounds is of course of paramount importance to the general practitioner because it has placed in his hand a tool with which he can control thyrotoxicosis usually for as long as he chooses to keep the patient on it. I should like to emphasize however, that all of these antithyroid compounds are occasionally capable of producing undesirable or even quite dangerous sensitivity reactions. The propyl and methyl derivatives of thiouracil are very much less toxic than was thiouracil itself, but even these compounds must be regarded

as potentially toxic. The same thing is true of an antithyroid drug which we have found to be generally highly satisfactory and that is methylmercaptoimidazole as it is called, and it is marketed under the name of "tapazole." Even this compound will occasionally produce leukopenia. The manufacturers tell me they have received reports of an incidence of agranulopenia of serious degree in a little under 0.2 per cent in more than a thousand case reports which they have received. The response of patients to long continued therapy with these antithyroid drugs is of interest. We reviewed a group of forty-six patients all of whom had been on one form or another of these antithyroid drugs for a long period of time. They were selected cases in whom we started out deliberately with the hope of producing a permanent or sustained remission without any other therapy than antithyroid medication. Most of these forty-six patients had been followed for more than two years after the withdrawal of the medication and some of them had been followed for as long as seven years. We found somewhat to our surprise that of those forty-six, forty had remained in satisfactory remission and only six required some other form of treatment. A number of those forty, it is true had relapsed once or twice, sometimes three times but then eventually had gone into what we call a "permanent" or sustained remission.

Q. DR. FORT: A female patient of fifty years, with a large nodular goiter, who had received iodine for nine months, and whose basal metabolic rate is now plus eighty per cent, is to be prepared for operation with propylthiouracil. Should stable iodine be discontinued at this time?

DR. ROSE: Dr. Carey, would you care to answer that?

DR. CAREY: I would certainly continue the stable iodine because a sudden withdrawal carries with it a grave risk of precipitating a crisis. The antithyroid drugs are far too slow in their reaction to protect a patient throughout that period, so I believe that she should be started on the

antithyroid drugs, and that iodine should be continued up until the time of operation.

DR. ROSE: Dr. Rienhoff, would you agree to that or would you care to dissent?

DR. RIENHOFF: No, I think it should be continued. After all, I think all surgeons agree that if you do not continue iodine that you have a technical problem which is at least more difficult than if you have a sustained involution of the gland that you can only get with iodine. Otherwise you really have a vascular gland that persists in its hypertrophy and hyperplasia and vascularity which offers at least more difficult technicalities. There doesn't seem to be any harm in continuing the iodine along with the propylthiouracil.

Q. Dr. Asper, please discuss the use of radioactive iodine in metastatic carcinoma of the thyroid.

DR. ASPER: This also is in development. It appears that certain patients who have carcinoma of the thyroid are suitable candidates for intensive treatment with radioactive iodine. There are patients, however, in whom radioactive iodine may be used diagnostically in an attempt to determine whether or not metastases are due to thyroid cancer. However, in the presence of normal thyroid tissue in the neck, when a tracer dose of radioiodine is given, the iodine usually goes to the normal cells and is not accumulated by the carcinomatous cells. It therefore becomes necessary to remove all normal thyroid tissue from the neck before the metastases begin to develop any avidity for the iodine. As a diagnostic procedure for determining whether or not a metastasis is thyroid carcinoma, radioiodine has not been very successful except in a few cases.

When one uses radioiodine for thyroid cancer, large doses are required and usually it is necessary to attempt to induce the thyroid cancer to take up the radioiodine. The methods used to induce the tumor to take up radioiodine are administration of thyrotropic stimulating hormone (T.S.H.) thiouracil or propylthiouracil for

a period, then withdrawing it and administering radioiodine. The administration of antithyroid drug in a patient who has had the normal thyroid removed, will result in some stimulation of the metastatic tissue probably by the elaboration of TSH by the patient's pituitary gland. Then after withdrawing the antithyroid agent the tumor may take up significant quantities of radioiodine. There are patients reported in whom very satisfactory improvement has been obtained, however, I think radioiodine in the treatment of thyroid cancer has not lived up to the expectation that was held for it five or ten years ago.

Q. DR. FORT: If the antithyroid drugs block the iodination of the thyroid gland, how does the concurrent use of iodine and propylthiouracil prove beneficial?

DR. ROSE: Dr. Carey, would you undertake that?

DR. CAREY: Though the antithyroid drugs do prevent the thyroid from accepting large quantities of stable iodine, stable iodine does have the remarkable ability to prevent the hyperplasia that goes with the antithyroid drugs, and to lessen it once it has been established.

Q. DR. FORT: Dr. Dixon, please discuss your feelings as to the psychic phase in the etiology of Graves disease?

DR. DIXON: Well, that is of course a very controversial subject, very difficult to get convincing evidence, particularly to the practical minded surgeon, internist and others. Of the studies that have been done on many cases, there are three which I would refer to as good studies, two of them back in 1930's, both in New York, and more recent one at the thyroid clinic at Johns Hopkins Hospital, by Dr. Whitehorn and Dr. Lidtz. The ideas which have come out of these studies are in agreement as to the evidence found which is that emotional shocks or a strong emotional experience does have some relationship to the onset of the clinical thyroid disease. This of course is a question still open to debate. There are other more long range emotional problems in these patients' lives in the ones who

have been studied closely. There is evidence that thyrotoxicosis does relate to emotional conflict over the people close to them. One finds specific emotional problems simmering away for longer periods at the onset of clinical thyroid disease. These findings are based on careful examination of each patient and by noting their emotional response during the interview. In regard to talking about these problems, all I can say is that the investigators have gone into it carefully and come out with surprisingly similar ideas about the role of emotional problems both long range and acute emotional crises having some relationship to the onset and to the keeping alive of the disease.

Q. This is to Dr. Asper. If a hyperthyroid patient is being prepared for surgery on propylthiouracil and is sensitive to Lugol's solution, would you remove the propylthiouracil a few days before surgery?

DR. ASPER: No, sir, we have had such an experience and have kept the patient on propylthiouracil and had the gland removed without previous administration of Lugol's solution. Recently in a few patients in the clinic who have been receiving propylthiouracil for a prolonged period, two years or so, and have not had any reduction in the thyroid gland size, we have asked our surgeon confreres to remove the gland without previous administration of Lugol's solution. To our surprise these operations have gone extremely smooth. It is not felt, however, that such procedure should be advocated especially in patients who are treated only for a short period with propylthiouracil. One might add that when one uses propylthiouracil in preparation for surgery, that the drug should be given for a considerable period;—that is, at least three months—because it takes that long for the metabolism to be restored to normal. In such a patient who is sensitive to iodine, I think it might be safe to give the drug for a considerable period, a year or so, and then attempt to remove the gland without previous administration of iodine.

Q. DR. FORT: The final question will go to Dr. Rienhoff. Discuss indication for lymph node (block dissection of the neck) in malignancy of the thyroid.

DR. RIENHOFF: I think that was brought out very well by Dr. Berthrong. We divided our carcinomatous tumors into really three main groups, if you leave out the Hürthle cells. One of them is the intracystic papillary adenocarcinoma which undoubtedly goes by the lymph stream. It is probably the only instance in which you go into the neck to remove the lymph glands and then find it has thyroid tissue in it and you then do a hemilobectomy. I prefer a double partial lobectomy, but for this tumor you must do a dissection of the glands of the neck. I don't know exactly what some people mean now by a radical dissection. If you go by the radical dissection that we used to do in the days of Dr. Halsted and Dr. George Crile, I'd say no. We do take the lymph glands out from under the internal jugular, and the deep cervical glands on the side in which the lobe that we presume or assume does contain the tumor. On the other hand the so-called and the most paradoxical term I have ever heard, benign metastasizing adenoma. There isn't anything benign about metastasizing in my mind, but they do say that and they invade blood vessels. Dr. Berthrong pointed out, they do not metastasize through the lymphatics, they go through the blood stream. Now, those tumors can be removed and I don't think it is necessary to do a block dissection of the neck. Infiltrating carcinoma, is so rapidly growing, (the undifferentiated cell carcinoma) that I think they metastasize both by the blood stream and the lymphatics. Dr. Rose, may I make a remark about iodine and propylthiouracil? One of the things that has interested us for the last several years, has been the study of biopsies of the gland before, during and after propylthiouracil, in those who have been on the drug for two or three years. The thing that fascinates me about these drugs is not so much that I think we want to keep them all for sur-

gery, because I said in the beginning I'm completely convinced that medicinal therapy will finally answer the question. However, when thiouracil, which blocks the iodination of diiodotyrosine to thyroxin, is administered the gland undergoes hypertrophy and hyperplasia and then you give Lugol's solution and for some reason or other colloid is thrown down. In the days before the antithyroid drugs, we gave Lugol's solution and we had a colloid tamponade which cut down not only the lymph but the blood vascular circulation and the two processes seem to be entirely different; whether the iodine affects the epithelial cell we don't know, but it certainly will produce colloid. Where the colloid comes from we don't know but we do know that when blood thyroxin is down, and when blood iodine is down to normal you have a complete remission

from propylthiouracil. Even then, when you give Lugol's solution, you can precipitate colloid. I think the implementation of these drugs is fascinating and that they give us some tools to try to understand the mechanism of the thyroid gland. Evidently the two, iodine and propylthiouracil have two entirely different actions. It is fascinating to know why iodine can be precipitated in the absence of thyroxin production.

DR. McLANAHAN: I don't know how many sets of the Encyclopedia Britannica we have given away tonight, but we certainly have succeeded in escaping with a minimum number of contusions and lacerations among the members of the panel. I want to thank all of them for their splendid cooperation and say good night to all of them.

LINGUAL THYROID¹

ZACK J. WATERS, M.D., KENDRICK McCULLOUGH, M.D. AND
NATHANIEL R. THOMAS, M.D.

The first case report of lingual thyroid is credited by all writers to Hunt, who presented a case report in 1865.

Lingual thyroid or lingual goitre has been the subject of complete treatises, notably at the hands of continental writers. Dore, in 1922, reviewed the literature and presumably brought it to date with a total of 80 cases, his own making 81. It is possible, however, to identify between Hunt's report in 1865 and Dore's thesis in 1922, 91 additional cases, or a total of 172 cases. In 1922, two reports were published in addition to Dore's. Subsequent to Dore's publication, 72 cases have been reported. Recent writers have referred rather loosely to "about 130 cases reported in the literature," but the total is nearer 242.

Eiselberg, as well as many other authors, give credit to Verneuil for first recording the presence and identification of thyroid gland tissue elsewhere in the neck than the main thyroid body. Verneuil himself, however (1853) gives prior credit to Cruveilhier (1852) for recognizing thyroid tissue elsewhere in the neck than the normal location and to Le Gendre (1852) for prior description of the pyramid, along which they found thyroid rests. Says Verneuil: "I have little to add to this description (Cruveilhier's). In later times, in dissecting the insertion of the muscles of the tongue to the hyoid bone, I have run across a small mass of tissue of glandular appearance, strongly adherent to the lower part of the superior border of that bone, between the geniohyoid and the genioglossus. This mass was red, soft, buried; of the volume of a large pea, with a smooth surface, of a homogeneous ap-

¹ From the Departments of Otolaryngology and Pathology, Peninsula General Hospital, Salisbury, Maryland.

pearance; I have examined it microscopically and found thyroid gland tissue."

Lahey (1924) identifies aberrant thyroids according to location as follows: Those which remain at the foramen caecum are the true lingual goitres; those within the tongue, the intralingual goitres; those below the tongue, the sublingual goitres; those in front of the larynx, the pre-

Thyroid anomalies occurring in the tongue are of interest to the surgeon not only because of the practical problems involved in their surgical treatment but also because of their embryologic origin and the various parenchymatous changes to which they are subject. The favored site for the occurrence of thyroid tissue in the tongue is at its pharyngeal portion in the region of the

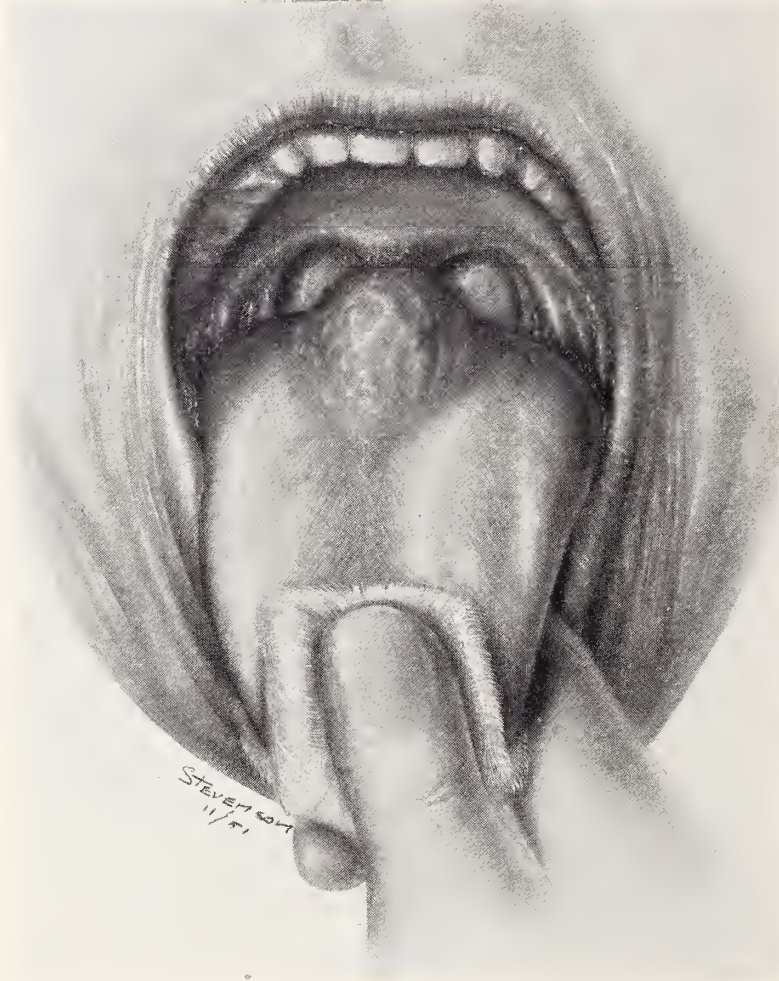


FIG. 1. Sketch of tumor mass, tongue drawn forward, showing contact with uvula and palate with ulceration

laryngeal goitres. Two other locations are within the superior mediastinum and those just outside the sternomastoid muscle in the posterior triangle of the neck. "Allied accessory thyroid" is an extruded adenoma still attached to the thyroid by fibrous band. "Pseudoaccessory thyroid" has an isthmus of true thyroid tissue, joining the mass to the thyroid. "True accessory thyroid" has no connection with the normal gland.

foramen caecum. Lingual goiter should be applied to hypertrophic thyroid tissue at the base of the tongue in those instances of nonmigration of the thyroid anlage from the region of the foramen caecum.

Lingual thyroid is essentially an embryological malformation, a vestigial rest appearing on the base of or within the tongue, or below it along the course of the thyroglossal duct of His. We can surmise no cause for this malformation.

It is found in women in seventy-four percent of the cases reported (78 in the female, 27 in the male, the sex not being indicated in 37 cases).

It is reported that in seventy percent of the cases the thyroid in the neck is absent, a fact,

on the base of the tongue. The referred diagnosis was "cyst of the tongue."

Family history: She has five brothers and three sisters, all living and well.

Past history: She had rickets in early childhood

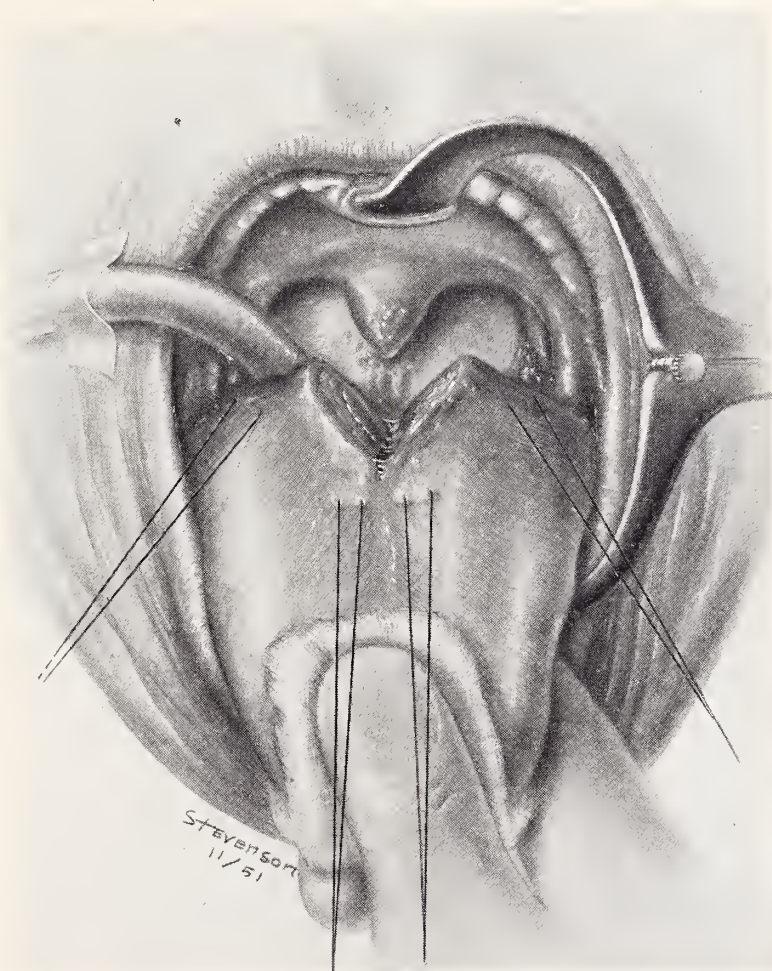


FIG. 2. Sketch of V shaped portion of tumor mass excised, traction sutures and emergency ligatures in place. (Note here ulceration of uvula, palate and posterior pharyngeal wall.)

which calls for consideration before surgical treatment is instituted.

REPORT OF A CASE

B. T. is a white female, aged 12, fairly well developed, moderately nervous, referred to me by one of us who had seen the patient on the previous day, February 22, 1951, complaining of a bloody discharge from the mouth of several days duration; also difficulty in swallowing, muffled speech, and a marked choking sensation. The referring physician noticed a large raw mass

and did not walk until the age of three. Usual childhood diseases. The history elicited from the family was that her nervousness dated back to December 1950, or three months previous. The mother had noticed for several weeks that there was a bloody mucous-like discharge on the pillows in the morning and occasionally the patient would spit up some blood-tinted mucous. Difficulty in swallowing had become rather pronounced, with some pain, and a definite so-called "thickening" or impairment in speech, also of several days duration.

Menstrual history: She began menstruation at the age of 11, regular, fair flow with little or no cramps.

Physical examination: The patient is an unusually cooperative, moderately nervous child, weighing 100 pounds, blood pressure 120/80, pulse 96, regular, no murmur. Physical examina-

tongue (See Figure 1). The throat was then sprayed with 2% pontocaine solution and an indirect laryngoscopy was performed. The mass was seen to occupy the most posterior aspect of the dorsum of the tongue and had no continuity with other structures of the pharynx or larynx. No other growths were noted. A direct laryn-

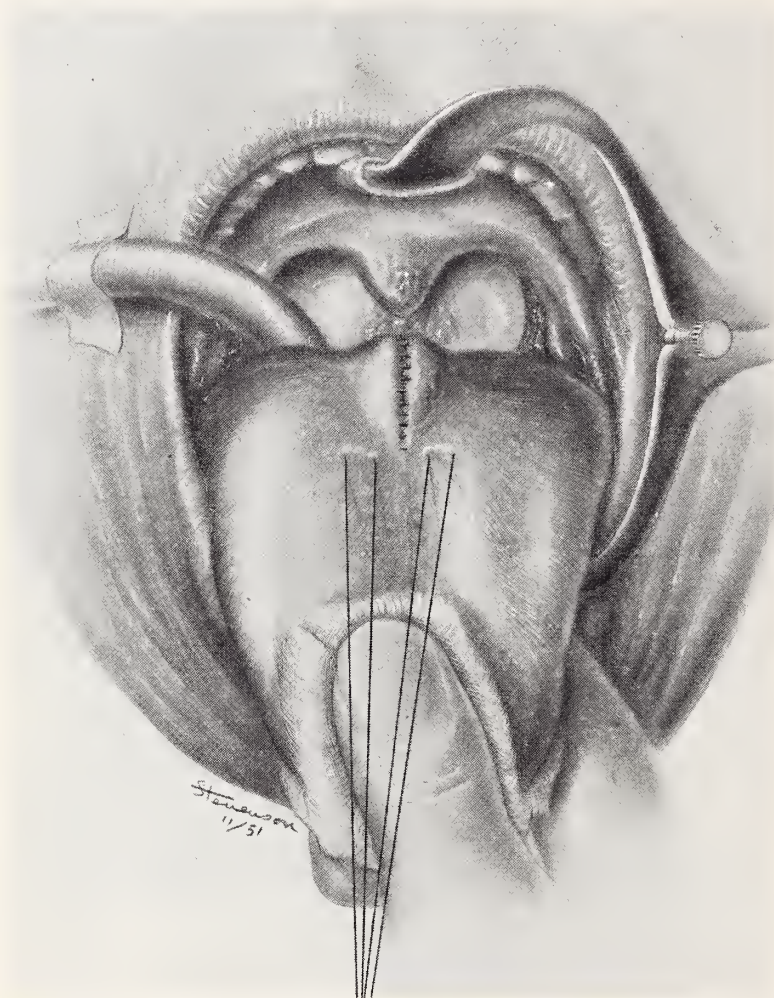


FIG. 3. Sketch showing approximation of remaining tumor mass with No. 0 braided silk sutures. (Note marked increase in pharyngeal space and airway.)

tion was essentially negative as far as the nose and throat was concerned except for hypertrophied and infected tonsils and a large, soft, hemispherical, elastic mass in the midline of the dorsum of the tongue, the mass measuring about 3 cm. in width, 4 cm. in length, and $1\frac{1}{2}$ cm. in height. The apex of this mass was ulcerated; the color was reddish. It was covered, except for the ulcerated area, by the mucous membrane of the

gloscopy was done and the same findings were noted. It could be seen that the apex of this mass during the process of deglutition was making contact with the palate; hence, the explanation of the ulceration and difficulty in swallowing. An attempt was made to aspirate its contents, using a 20 gauge needle and 5 cc. syringe, but with no avail; the thought being a possibility of a cyst of the tongue.

The patient was admitted to the Peninsula General Hospital on February 23 and on February 24 a further attempt was made to establish a diagnosis and, under local anesthesia, consisting of 2% pontocaine spray, augmented by $1\frac{1}{2}$ grains of nembutal given $1\frac{1}{2}$ hours before examination and $\frac{1}{2}$ grain codeine given 45 minutes before time of operation, and this further augmented by local

showed Ectopic Thyroid Gland-Oral Cavity. The basal metabolism on this day, being done in the early morning previous to the above procedure, was found to be plus 15. On admission, February 23, the blood count showed a rather marked reduction in hemoglobin and a moderate drop in red blood cells. The urinalysis was normal on admission.

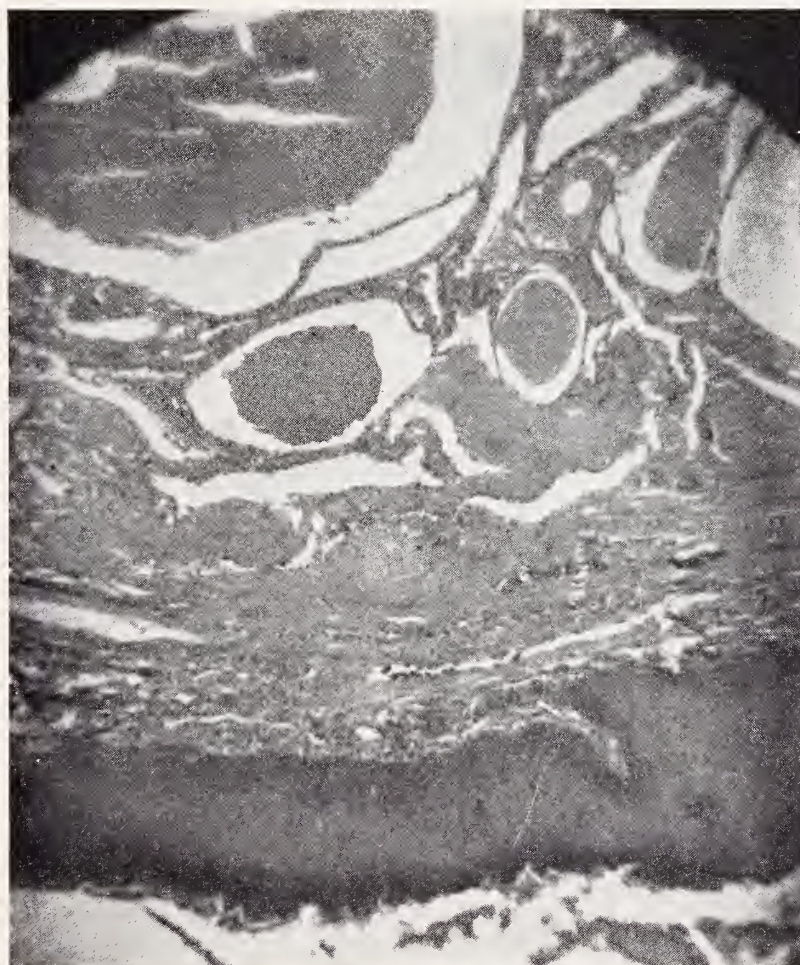


FIG. 4. Biopsy of Mass— $\times 1000$ Hematoxylin—eosin stain. 6 mm. thickness

infiltration around the circumference of the mass with novacaine 1% with adrenalin chloride; a small elliptical incision was made from the apex down through the entire substance of the mass; removing a small "watermelon-like" slice. Very little bleeding was encountered and two 4-0 silk sutures were used to approximate the edges. This specimen was sent to the laboratory and a frozen section requested. The frozen section

Report of First Biopsy

Specimen is a soft red fragment: 1 by 0.7 cm.

Frozen section shows a mucosal surface with stratified squamous epithelium. Attached to it is a glandular structure resembling thyroid.

The fragment on paraffin section, shows a covering of mucosa of the oral type. Beneath it is an area of thyroid tissue with large glandular acini filled with colloid. (See Figure 4).

On the morning of February 26, 1951, under general anesthesia, an endotracheal tube having been passed without any difficulty, the tongue being pulled well forward by two silk sutures placed on either side near its tip, and with suitable ligatures already in position to be tied lateral

the endotracheal tube and it was not found necessary to tie the sutures previously placed laterally on either side of the mass.

The patient was returned from the operating room in excellent condition and a transfusion already prepared was not found necessary. On

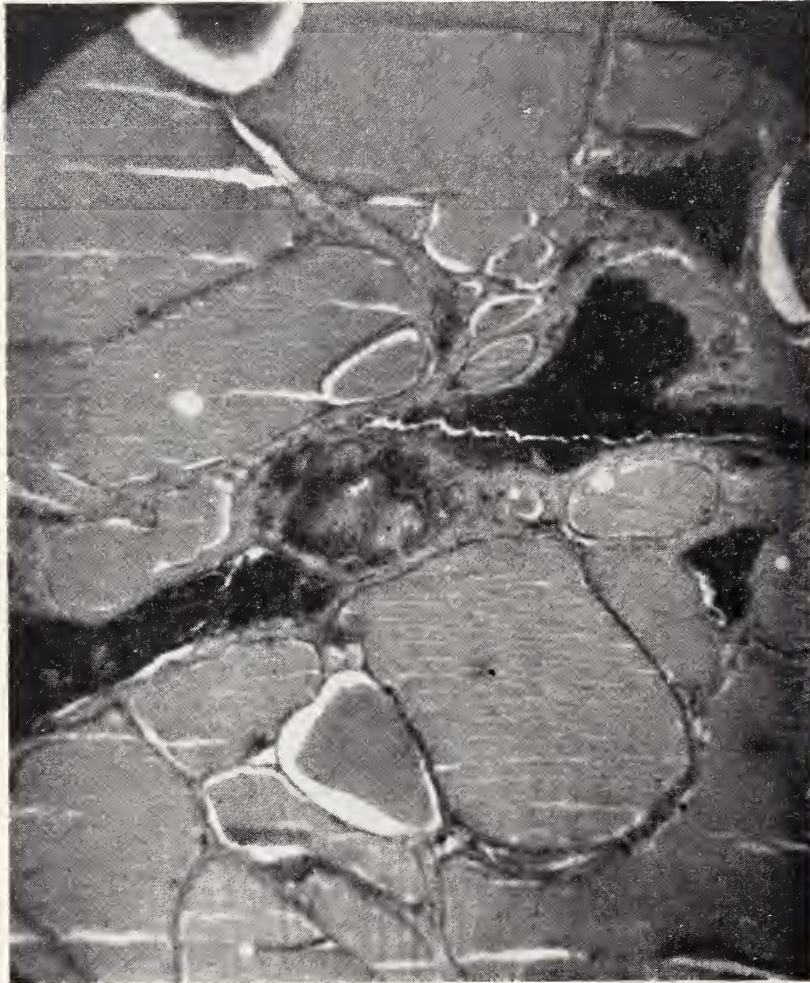


FIG. 5. Section of Interior of Mass— $\times 1000$ Hematoxylin—eosin stain. 6 mm. thickness

to the mass on the dorsum and posteriorly; a subtotal removal of this thyroid tissue was performed (See Figure 2). An elliptical incision was made and an equal portion taken on either side of the center through the entire thickness of the visible portion of the mass. Approximately one-half of the visible mass was removed in this manner. The edges were carefully approximated with No. 0 braided silk sutures (See Figure 3). Not too much bleeding was encountered although the pharynx had been carefully packed around

March 3, 1951 the basal metabolism rate was plus 5.

Report of Examination of Mass Removed at Operation

An irregular piece of firm, brown tissue is 2 by 1 cm. with mucosa on one side.

Histologic examination shows thyroid tissue with large acini filled with colloid. Over it is mucosa of the type found in the mouth. The site of the biopsy is marked by a hemorrhagic area

in the mucosa which includes suture material. (See Figure 5).

COMMENTS

The authors felt that the BMR plus 15 was represented by the mass on the base of the tongue and that extreme care must be taken in its removal lest we find our patient postoperative in a state of myxedema thus making it necessary that she take thyroid for the rest of her life. Furthermore, we were cognizant that this mass fluctuated in size and that the symptoms were enhanced by menstruation, and it was just following the menstrual period that the patient was seen. However, in view of the symptoms aforementioned and discomfort, plus the moderate and continuous loss of blood, a partial or subtotal removal of this mass was deemed necessary without further ado.

Since the surgery was to be performed by one of us, an otolaryngologist, the oral route was elected. We had no hesitancy in explaining to the family prior to the operation that this mass was thyroid tumor and that its removal might be attended by some gain in weight or necessitate the use of thyroid. Fortunately, a monthly check over a twelve-month period has failed to present any evidence of dysfunction, and we feel reasonably sure that enough time has elapsed that myxedema present itself. No such symptoms or signs are apparent.

In July 1951 a tonsillectomy and adenoidectomy was performed with an uneventful recovery. A BMR has been done each month since the date of operation and has ranged from a plus 5 to a minus 4.

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Symposium on The Doctor In Court will be continued in the June Journal.

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COURT RULES THAT KEY SECTIONS OF LOBBYING LAW ARE UNCONSTITUTIONAL

Capitol Clinic, A. M. A., Vol. 3, No. 12, March 25, 1952

A special three-judge U. S. District Court has ruled that the key provisions of the federal lobbying law are in violation of either the first amendment or the "due process" clause of the fifth amendment to the Constitution and are unconstitutional. The Justice Department may appeal directly to the Supreme Court, and there is a possibility that Congress will amend the law to conform to the lower court's decision. If the lower court is sustained, and if Congress fails to act, only one section of the law will remain, that requiring *individuals* who lobby for *pay or other considerations* to register with the Clerk of the House and with the Secretary of the Senate and to file certain quarterly reports. The court did not rule on this section. However, inasmuch as the penalty provisions were held unconstitutional, there would be a question as to the effectiveness even of this section. *Write to AMA's Washington Office if you want a copy of the court's decision.*

Component Medical Societies

ALLEGANY-GARRETT COUNTY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. John A. Dyer, formerly of 247 Virginia Avenue, Cumberland, has been promoted to the rank of captain of Malden Air Force Base, Missouri, where he is flight surgeon and head of the medical department.

Captain Dyer was stationed at Randolph Field, Texas, and Columbus, Mississippi, prior to being sent to Missouri. His wife and daughter, Carolyn, are with him. He is the son of Dr. and Mrs. Vernon L. Dyer, Petersburg, West Virginia.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.

Journal Representative

The basic plan for the new addition and improvements to the Anne Arundel General Hospital has been approved by the State Planning Commission. Construction is expected to begin about July 1, 1952. The new orthopedic rooms, including a waiting room and a supply room, have been completed and are now in use at the hospital.

Dr. Harold R. Bohlman lectured to the Maryland State Nurses Association, including nurses from Anne Arundel, Calvert and Prince George's Counties, on the subject of recent and present cases of orthopedics with x-ray discussions. There was a large attendance for this first lecture.

Dr. J. Howard Beard, of the County Health Department, spoke yesterday to the Anne Arundel County nurses on the formation of Civil Defense units. Approximately fifty nurses were present.

BALTIMORE COUNTY MEDICAL ASSOCIATION

DONALD L. SOMERVILLE, M.D.

Journal Representative

The Baltimore County Medical Association held its monthly meeting on February 20, 1952, at the

Mullineaux Restaurant in Catonsville. The guest speaker was Dr. Lawrence Schulman, of the Johns Hopkins School of Medicine. An excellent paper on the use of ACTH and Cortisone was presented.

After discussing various aspects of the use of these hormones, Dr. Schulman stressed the fact that proper laboratory workup and followup are of utmost importance. These drugs cause changes in many systems of the body, and it is essential to keep check on the changes. As the speaker stated, "These hormones are not a panacea, nor are they a poison. They must be used wisely and cautiously, if they are to be used at all." The presentation was accompanied by a film on ACTH. The film showed some of the dramatic results one may get at times with the use of these drugs.

In the business section of the meeting, the revised constitution and by-laws were accepted by the membership at large. The newly formed Public Relations Committee presented some of its plans for the coming year. Plans were formulated for the designing of an emblem or insignia. The idea of an art contest among county high schools for the designation of such an emblem was discussed. This plan is to be further investigated.

The Public Relations Committee also brought up the possibility of blood typing all county residents as part of the civil defense effort. This is to be discussed with the State Civil Defense Authorities.

The Baltimore County Medical Association held its monthly luncheon meeting at the Rosewood State Training School on March 19th. Through the courtesy of Dr. George Wadsworth, Rosewood Superintendent, a wonderful chicken dinner was served to the members.

A short business meeting followed the luncheon.

After many faithful and devoted years of service, Dr. Frank Glantz tendered his resignation as Historian. His position was immediately filled by Dr. George Medairy.

An Art Contest which was brought up by the Public Relations Committee at the February meeting, was again discussed. This contest is to be held among all students of the county high schools. The purpose of the contest is to obtain a design for an

emblem or insignia to be used by the Baltimore County Medical Association. The contest has been approved by the County Board of Education and will be more fully publicized in the very near future.

The scientific part of the meeting was extremely interesting. The program consisted of a symposium on "The Mongoloid Child." This subject was presented in various aspects by members of the Rosewood Staff under the leadership of Dr. George Smith, Consulting Neurosurgeon of the University of Maryland. He introduced the subject and gave a discussion on the neurology involved. The following men also spoke:

Dr. Harry Butler—Physical characteristics and presentation of typical mongoloid patients.

Dr. Charles Ward—Endocrine patterns and their relationship to treatment.

Dr. John Brackin—X-ray findings in mongoloids.

Dr. Samuel Scalia—Congenital abnormalities of the heart among mongoloids.

It was stressed that early diagnosis is very important, for these children require institutional care. Many of them can be given some form of training to better their status in life.

MONTGOMERY COUNTY MEDICAL SOCIETY

L. MARSHALL CUVILLIER, JR., M.D.

Journal Representative

The monthly meeting of the Society, March 18th, was highlighted by the presence of almost fifty physician's wives and one physician's husband. This was the annual joint meeting with the women's auxiliary and an active campaign for increased membership was launched by them.

An interesting scientific presentation was made by

Dr. Hugh Hussey of Georgetown University, giving views on latest diagnostic and treatment procedures for gastro-intestinal bleeding.

After this scientific lecture, the business meeting was conducted and elections of officers accomplished. The panel as elected for 1953, agreed totally with recommendations of the nominating committee. All officers were unanimously elected. Only one opposing nomination was made and he requested withdrawal of his name.

Officers for 1953 are: *President*, William S. Murphy, Rockville, Maryland; *Vice President*, Austin B. Rohrbaugh, Jr., Chevy Chase, Maryland; *Secretary*, L. Marshall Cuvillier, Jr., Silver Spring, Maryland; *Treasurer*, Henry P. Laughlin, Chevy Chase, Maryland.

Delegates: Claude W. Mitchell, Silver Spring, Maryland, and William W. Welsh, Rockville, Maryland.

Alternate Delegates: John G. Ball, Bethesda, Maryland, and W. McKendree Boyer, Damascus, Maryland.

New Member to Board of Censors: Wilfred W. Eastman, Silver Spring, Maryland.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

SAMUEL J. N. SUGAR, M.D.

Journal Representative

At the April meeting of the Prince George's County Medical Society, Dr. Marshall Sanford spoke on Treatment of Bleeding Esophageal Varices.

Plans for a Golf Tournament, to be held in June, have been completed by Dr. Musser. Dinner and Entertainment will follow the afternoon of Golf, at the Prince George's Golf and Country Club.

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Don't miss the Annual Convention, Woman's Auxiliary to the American Medical Association June 8-13, 1952, at The Conrad Hilton Hotel, Chicago, Illinois. Make reservations now! Notify Mrs. Charles H. Williams, President, 1632 Reisterstown Road, Pikesville, Maryland, as soon as you know that you are going. She may want you as a delegate!

Library

RECENT ADDITIONS IN THE LIBRARY

1. Altschul, Rudolf, Selected Studies on Arterio-Sclerosis.
2. Benedict, Edward B., Endoscopy.
3. Berman, Jacob K., Principles and Practice of Surgery.
4. Brain, W. Russell, Diseases of the Nervous System. 4th Ed. 1951.
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REED-KEOGH BILLS

Secretary's Letter, No. 212, March 21, 1952

Instead of urging inclusion of doctors under Social Security, the A. M. A. is joining hands with the American Bar Association, the American Dental Association, architects, engineers, accountants and other professional groups in support of the Reed-Keogh bills, which provide for exclusion of certain portions of earned income from federal income taxes if those amounts are used to buy a pension.

These bill have been approved in principle twice by the House of Delegates of the Medical and Chirurgical Faculty.

Health Departments

MARYLAND STATE DEPARTMENT OF HEALTH

Some Changes in Communicable Disease Reporting

By action of the State Board of Health, and in line with policies current in other States and in the U. S. Public Health Service, the list of communicable diseases which must be reported to county and city health officers in the State of Maryland, has been modified.

Added to the list are the following diseases: Hepatitis, infectious; Hepatitis, serum; Leptospirosis, including Weil's disease.

Dropped from the list were: Influenza, Pneumonia, Puerperal infections, Rheumatic fever.

This leaves the complete list of reportable diseases as follows:

Amebiasis	Non-paralytic
Anthrax	Unspecified
Botulism	Psittacosis
Brucellosis	Rabies in man
Chickenpox	Rabies in animals
Cholera	Rocky Mountain spotted fever
Dengue	Salmonellosis (Paratyphoid)
Diarrhea (newborn)	Shigellosis (Dysentery)
Diphtheria	Smallpox
German measles	Streptococcal sore throat including scarlet fever
Glanders	Tetanus
Hepatitis, infectious, including hepatitis, serum	Trachoma
Infectious encephalitis (by etiology if known)	Trichinosis
Leprosy	Tuberculosis (all forms)
Leptospirosis, including Weil's disease	Tularemia
Malaria	Typhoid fever
Measles	Typhus fever, endemic
Meningococcal meningitis and meningococcemia	Typhus fever, epidemic
Mumps	Yellow fever
Ophthalmia neonatorum	Venereal diseases
Pertussis (whooping cough)	Chancroid
Plague	Gonorrhea
Poliomyelitis	Granuloma inguinale
Paralytic	Lymphogranuloma venereum
	Syphilis
	Primary and secondary
	All other

In an effort to inform practitioners of the preva-

lence of reportable disease in the community, a monthly report of communicable diseases for the State of Maryland will be published in each issue of the Maryland State Medical Journal. (See page 255).

Before making the changes in the diseases to be reported, a review of the Morbidity Reporting was submitted to the board by Dr. James R. Strain, epidemiologist assigned by the U. S. Public Health Service to the Maryland Health Department. The purposes of morbidity reporting were described as follows:

1. To make it possible to begin control measures at the time of their greatest potential effectiveness.
2. To measure the effectiveness of existing programs of prevention and to make possible further improvement.
3. To collect and analyze the statistical data necessary for immediate and future guidance of administrative procedures.
4. To disseminate knowledge of the prevalence of reportable disease in the community and to secure the cooperation of the general public in its prevention.

"Since routing morbidity reporting requires the regular and effective cooperation of many individuals who receive no compensation for the service," the report points out, "it is evident that the list of diseases to be reported should be limited to those conditions whose reporting is clearly necessary for the fulfillment of the above purposes."

Commenting on the omission of influenza and pneumonia, the report indicates "All efforts at the prevention of acute respiratory diseases have up to this time been completely futile and their diagnosis is so uncertain that individual case reports are of no statistical value.

"It is, however, desirable that the unusual prevalence of respiratory diseases or the appearance of new types be reported. As these diseases seem to be gaining in relative importance, it is essential that effort be made to develop new methods for their diagnosis and control."

During the 48th annual conference of the State and Territorial Health Officers held October 19-22 of 1949, the Infectious Disease Committee made the

following recommendations on the subject: "The Public Health Service study and survey present reporting requirements and make recommendations concerning any changes which are deemed advisable." The Service later reported that "Influenza reports are notoriously inaccurate and more useful data regarding the occurrence of this disease will be obtained by a plan of reporting of epidemics." This was also the feeling concerning pneumonia. This committee went on to state—"... individual case reporting of influenza is grossly unsatisfactory because the disease cannot be diagnosed clinically and is indistinguishable from many other types of common endemic and epidemic manifestation covering wide expanses of territory almost simultaneously, and causing a degree of increased morbidity and absenteeism sufficient to become readily apparent to the general public. It is relatively easy for a health officer to secure a qualitative description of the occurrence and extent of an influenza epidemic in his jurisdiction by telephoning schools and a few major industries to determine roughly absenteeism for respiratory disease. If local health officers are instructed to report such events to the State Epidemiologist, he in turn could quickly secure a picture for the whole state more promptly and more accurately than he could by the more cumbersome impractical method of individual case reporting." They further recommended that some mechanism be devised for the recognition of any increase in the number of pneumonia deaths.

The consultants of the Communicable Disease Center of the Public Health Services on considering these proposals, expressed certain differences of opinion on the subject. At the conference of State Epidemiologists in Atlanta, Georgia in April 1951, however, these two groups of diseases were recommended to be dropped from routine reporting.

In association with the civil defense program, Dr. Allen W. Freeman wrote a memorandum to the county health officers on January 23, 1951 requesting a narrative report of any unusual prevalence of disease. The influenza information center of the World Health Organization has arranged with laboratories in each region of the United States to do diagnostic work with influenza. As soon as a positive test is made in any one of these laboratories, the result is made available to all public health personnel.

Rheumatic Fever:—It is recommended that Rheumatic fever be dropped from the list of reportable diseases since no immediate control measures are undertaken to prevent its spread. Dr. Edward Davens states also that the diagnosis of Rheumatic fever is, in many instances, extremely difficult and concludes from study of past reports of this disease, that they are grossly inaccurate and of no real value. His proposal has been discussed with Dr. J. Edmund Bradley, Chief of Pediatrics at the University of Maryland, Dr. Francis F. Schwentker of Johns Hopkins and Dr. E. Cowles Andrus of the Heart Association of Maryland. All agreed to the proposal for dropping this disease. They believe case-finding through special school and cardiac clinics to be a much more satisfactory approach.

Puerperal Infections:—Puerperal infections are now very rare. In fact we have had no cases reported in the past few years. This reduction in prevalence is thought to be due largely to the practice of aseptic technique and the prophylactic use of antibiotics.

Dr. John Whitridge, Consultant in Obstetrics for the Department, feels that due to the above facts and since all maternal deaths are thoroughly investigated by a medical committee, puerperal infections have virtually disappeared as a public health problem and the disease should be dropped from the list.

ADDITIONS TO THE LIST OF REPORTABLE DISEASES

It was recommended that certain diseases be added to the reportable list.

Infectious Hepatitis and Serum Hepatitis:—Diseases of this group are recommended to be routinely reported. There has been during and since the war years, an apparent increase in the number of such cases. Gamma Globulin has proven beneficial as an immediate preventive measure tending to prevent the spread of infectious hepatitis if given early to the contacts.

There have been several serious epidemics in our State during the past year and considerable amount of research is noted in progress on the subject. Much more needs to be done. With the increased use of human blood and blood products it is quite obvious that cases of serum hepatitis should be reported and the sources of infection discovered at the earliest possible moment. Reporting will also be of value in research.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, March 21-April 17, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	STREP. SORE THROAT, INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																	
Local areas																	
Baltimore County...	47	—	9	3	252	2	4	—	25	—	—	1	29	1	12	—	10
Anne Arundel.....	10	—	4	—	42	3	13	—	6	—	—	4	5	—	5	—	3
Howard.....	—	—	—	—	2	—	—	—	1	—	—	—	2	—	—	—	—
Harford.....	36	—	107	—	59	2	19	—	—	—	1	—	1	—	1	m-2	2
Carroll.....	7	—	—	—	21	—	6	—	3	—	—	—	3	—	2	—	4
Frederick.....	3	—	2	1	60	—	8	—	4	—	—	—	—	—	—	—	4
Washington.....	1	—	9	—	39	1	—	—	2	—	—	—	4	—	1	—	1
Allegany.....	4	—	3	—	2	1	5	—	3	1	—	—	8	—	1	—	3
Garrett.....	—	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	4
Montgomery.....	32	—	16	—	158	—	21	—	19	—	—	—	27	3	—	—	4
Pr. George's.....	9	—	26	—	48	—	8	—	3	—	—	—	—	—	—	—	4
Calvert.....	—	—	—	—	—	1	—	—	—	—	—	—	1	—	—	—	1
Charles.....	1	—	—	—	4	1	—	—	1	—	—	—	—	—	—	—	1
Saint Mary's.....	—	—	—	—	7	—	—	—	—	—	—	—	—	3	1	—	2
Cecil.....	—	—	1	—	2	—	3	—	—	—	—	—	3	—	1	—	1
Kent.....	—	—	—	—	26	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	—	—	2	—	—	—	3	—	—	—	—	—	2	—	1
Caroline.....	1	—	—	—	4	—	—	—	—	—	—	—	2	—	—	t-2	—
Talbot.....	—	—	—	—	2	—	—	—	—	—	—	—	—	—	1	—	—
Dorchester.....	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—
Wicomico.....	6	—	—	1	26	—	1	—	3	—	—	—	5	—	8	—	2
Worcester.....	—	—	—	—	1	—	—	—	—	—	—	—	1	—	—	—	—
Somerset.....	—	—	—	—	1	—	—	—	—	—	—	—	—	—	3	—	—
Total, counties...	157	0	177	5	760	11	88	0	73	1	1	5	92	7	39		47
Baltimore City.....	279	0	47	10	785	8	37	0	48	0	0	11	118	8	410	e-1	25
State																	
Mar 21-Apr 17, 1952	436	0	224	15	1545	19	125	0	121	1	1	16	210	15	449		72
Same period 1951...	494	11	176	47	597	6	726	0	117	3	2	35	194	25	409		70
5-year median.....	565	14	88	—	653	16	171	0	154	2	5	68	239	125	487		74
Cumulative totals																	
State																	
Year 1952 to date...	1707	4	501	98	7348	48	504	6	554	7	9	63	869	55	1919		316
Same period 1951...	1676	25	309	89	1228	29	2156	10	460	5	9	218	780	101	1987		241
5-year median.....	1990	101	205	—	1397	58	583	2	604	6	17	418	845	481	2062		325

e = infectious encephalitis.

m = malaria contracted outside the U. S. A.

t = tularemia, belated 1951 reports.

Weil's Disease or Leptospirosis:—Weil's disease, though not a problem in Maryland, is recommended to be reported. The disease is of national importance and over-all figures on prevalence should be available. With recent improvements in laboratory diagnosis it is likely that an increasing number of cases will be discovered. The disease is known to be widespread in the rat populations and reporting is necessary to further effective research into the many still obscure features of this disease.



Director

BALTIMORE CITY HEALTH DEPARTMENT

Fluoridation Approved for City Water Supply

On the basis of the best available scientific support, offered by the Medical and Chirurgical Faculty of Maryland, the Baltimore City Medical Society, the Baltimore City Dental Society, the Maryland State Department of Health and the National Institute of Dental Research of the U. S. Public Health Service, the City Council of Baltimore voted 17 to 4 in favor of the fluoridation of the city water supply on March 24, 1952. Others who encouraged this action included Dr. A. McGehee Harvey and Dr. Abel Wolman.

In the *Journal of the City Council of Baltimore* for March 18, 1952, pages 1238-1244, there appear the following Communications that were laid before the Council by its President, Mr. Arthur B. Price:

COMMUNICATION FROM BALTIMORE CITY DENTAL SOCIETY

Baltimore City Dental Society Resolution

Whereas, The Baltimore City Dental Society includes in its membership a great majority of the dentists of Baltimore; and

Whereas, The dentists of Baltimore are traditionally and by profession concerned with the dental health of the people of Baltimore; and

Whereas, Decay of the teeth poses a major health

problem affecting more than ninety per cent of the people of Baltimore; and

Whereas, People who live the first eight years of their lives where water supplies contain one part of fluorine in a million parts of water have less than one half as many teeth attacked by decay as do Baltimorean; and

Whereas, People who live their entire lives where water supplies contain one part of fluorine in a million parts of water do not have mottled teeth, brittle bones, poorly developed skeletons, nor increased susceptibility to rheumatism, arthritis, cancer, heart disease, hardening of the arteries, kidney disorder or premature death; and

Whereas, The safety of the presence of one part fluorine in a million parts of drinking water is substantiated in numerous epidemiological, clinical, laboratory and animal studies; be it therefore

Resolved, That the Baltimore City Dental Society reiterate its endorsement of the projected fluoridation of the public water supply of Baltimore given in 1950, and urge anew that the Mayor and City Council of Baltimore proceed to the end that the amount of fluorine present in the water supply be increased and maintained at the one part per million level as an economical, safe and effective means of reducing tooth decay and loss of teeth in coming generations of the people of this city.

Adopted, By the Executive Council of the Baltimore City Dental Society, Monday, March 10, 1952.

PAUL A. DEEMS, D.D.S.,
President.

COMMUNICATION FROM BALTIMORE CITY HEALTH DEPARTMENT

Baltimore City Health Department

Baltimore, March 13, 1952.

Dear Mr. Price,

Because of the communications published on pages 1148 and 1149 of the *Journal of the City Council of Baltimore* on March 3, 1952 in regard to the fluoridation of the Baltimore City water supply, I wish to send you the enclosed statement on this important public health matter that I presented, at the request of the Committee on Health for the City Council, at its hearing on March 3, 1952, and trust that the brief statement and this letter may be published in the *Journal of the City Council*.

You will see that all of the medical profession of the State of Maryland and the City of Baltimore, and the dental profession, and the Maryland State Board of Health favor the fluoridation of the Baltimore City water supply at this time.

May I add that the impression given on page 1149 of the Journal of the City Council under the heading "Doctor Raps Fluorine Use" is an entirely false one for these reasons:

Alfred Taylor of the University of Texas is a doctor of philosophy and not a physician. He is a biochemist research man. In my opinion, the results of his studies, after investigation by the U. S. Public Health Service, are worse than useless, because it is obvious he did not know what he was doing. In trying to study the effect of one part per million of fluorine in water, he experimented on 67 mice and, during the experiment, he fed them a dog chow food for their exclusive diet which, when analyzed, proved to contain 42 parts per million fluorine. Obviously, with this ignorance on his part, his experiments can mean nothing.

Sincerely yours,

HUNTINGTON WILLIAMS, M.D.
Commissioner of Health

STATEMENT OF DR. HUNTINGTON WILLIAMS ON
FLUORIDATION OF THE BALTIMORE CITY
WATER SUPPLY MARCH 3, 1952

In connection with Resolution No. 506 now before the Committee on Health of the Baltimore City Council asking for information on the fluoridation of the Baltimore City Water Supply.

The Commissioner of Health of Baltimore City believes thoroughly in

1. The fact that there is no substantial disagreement among competent scientists that the proposed fluoridation of Baltimore's water supply will have any effect at all of a deleterious nature on aging people, or on people of any age group.

In the Report on Fluoridation of Water Supplies of the National Research Council, published November 29, 1951, it is stated: "*In the accumulated experience there is no evidence that the prolonged ingestion of drinking water with a mean concentration of fluorides below the level causing mottled enamel would have adverse physiological effects.*"

The Chairman of the National Research Council Committee on this matter had as its Chairman, Dr. Kenneth F. Maxcy, Professor of Epidemiology, Dr. A. McGehee Harvey, Professor of Medicine and Dr. Abel Wolman, Professor of Sanitary Engineering; all three at the Johns Hopkins University, as three of the nine members of the Committee. Among the other members were representatives of the U. S. Public Health Service, the University of Cincinnati College of Medicine and the University of Minnesota School of Public Health.

This Report was printed in the January 1952 issue of *Baltimore Health News*.

2. The fact that any claims made that fluoride in the minute amounts to be added to the City Water Supply, one part per million, is harmful to persons suffering from rheumatism and arthritis, are not correct and cannot be scientifically confirmed.

In a leaflet published by the Baltimore City Health Department entitled "*Fluoridation—Questions and Answers*", Question No. 19 and its answer are as follows:

19. *Is it possible that fluoridation may cause defects in the body?*

Answer: No body defects attributable to water-borne fluorine below the 8 part per million level have ever been reported. Careful physical and x-ray examination of Newburgh children exposed to fluoridated water for six years disclosed no ill effects in the eyes, ears, bones, teeth or vital organs.

3. That the Baltimore City Health Department has been studying the matter of fluoridation of the City Water Supply since its first request to do so was received from Mayor Thomas D'Alesandro during the month of August, 1950.

That in November, 1950 the Baltimore City Dental Society approved the fluoridation of the Baltimore City Water Supply.

That in November, 1950 the Medical and Chirurgical Faculty of Maryland, the State Medical Society, placed itself on record as approving the fluoridation of the Baltimore City Water Supply.

That during 1951 the Maryland State Board of Health, after due consideration, approved the addition of fluoride to the city water supply of Hagerstown; and on December 20, 1951, approved the same procedure for Baltimore City.

4. That Dr. Maurice C. Pincoffs, Professor of Medicine at the University of Maryland, who serves with the Commissioner of Health of Baltimore City as a member of the Maryland State Board of Health, personally approves the fluoridation of the Baltimore City Water Supply as a safe and important procedure for the partial prevention of dental decay in children.

5. The fact that well water consumed by the citizens of Crisfield, Maryland, has been shown to contain three parts per million of fluoride in Somerset County and that they have been drinking this water for years and years without apparently any bad effects.

That in other Maryland communities there is naturally more than one part per million fluoride in the normal drinking water as follows:

Charles County:

Potomac Heights—3.00 parts per million

Indian Head— 2.5 parts per million

La Plata— 3.0 parts per million

Caroline County:

Denton— 1.30 parts per million

Dorchester County:

Cambridge— 1.10 parts per million

Talbot County:

Oxford— 1.80 parts per million

All of these are reports from the Maryland State Department of Health for Maryland areas, and there is no evidence that there has been any harmful effect from long continued drinking of these natural waters.

6. The fact that before chlorine was first used to prevent typhoid fever in public water supplies there was a feeling of uncertainty and possible danger to health which was clarified on a national basis in 1908.

The magnificent results as shown in the City Health Department Chart on the Typhoid Fever Death Rate from 1900 to 1950 from the adding of chlorine to the City Water Supply is now well accepted by the public and not to have chlorine

in the City Water Supply would be considered by nearly everyone as a public disgrace.

That the purpose of adding fluoride to the City Water Supply is identically the same, namely for the prevention of needless tooth decay and suffering for thousands of Baltimore children in the future, and for better adult health as the years go by.

7. That there is always some disagreement among scientists, and that this is perhaps the finest thing about science.

If it were not for some doubts and disagreement in science, there would be no true science.

From the best available evidence it would appear to the Commissioner of Health of Baltimore that well over 95% of the soundest scientific thought in the United States is in favor of the view that there is no danger to adjusting a city water supply to one part per million of fluoride and further that if this procedure is adopted that roughly two-thirds of all the dental decay in children, as the years go by, will be eliminated.

Because of the above the Commissioner of Health of Baltimore welcomes this opportunity to bring this available information to the members of the City Council as requested.

Huntington Williams, M.D.

Commissioner of Health

MEDICAL EDUCATION EXPANSION PROGRAM SURVEY

Secretary's Letter, No. 211, March 10, 1952

A survey conducted by the New York Times a few days ago showed the greatest expansion program in the history of medical education, to cost \$250,000,000, is now under-way in this country.

The Times surveyed 80 medical colleges and 48 state commissioners of education through questionnaires.

According to the survey, medical colleges will spend, within the next few years, \$50,000,000 for laboratories, \$30,000,000 for classrooms and \$20,000,000 for dormitories. Another \$100,000,000 is earmarked for research and special projects. In addition, the immediate cost for establishing new medical institutions will run above \$50,000,000, making an overall expansion program of a quarter of a billion dollars.

"To meet the increasing demands for more physicians and medically-trained men," the Times said, "at least 10 states have taken steps to build new medical schools or expand their two-year basic science schools into four-year institutions.

"In the current academic year—1951-52—the medical colleges admitted the largest freshman classes in recent history, a total of 7,381. . . . Despite the expansions now taking place, large numbers of qualified applicants are unable to gain admittance to any medical college in this country. Many of them seek places in foreign institutions. The records indicate that 20,000 individuals applied for admission to American medical schools for the current college year. As many of them applied to more than one institution, the total number of applications was more than 70,000, or an average of 3.5 a student."

Insurance

BLUE CROSS

Since it was started in 1937, Blue Cross has progressed both in its size and in its administrative set-up. Growing pains and changes have come about as a result of experience and also from the increasing desire of the general public for assurance of hospital care.

The whole field of a pre-payment plan for hospitalization was instigated and developed by Blue Cross. As the idea and the Plan spread it became necessary for adjustments to be made. Blue Cross was making the people hospitalization conscious and as result changed its policy to enable larger groups to join.

Ever since its origin Blue Cross has been local in character. Each Plan has been set up to answer the needs of its own community. Each one reflects the economic realities of its own neighborhood. The differences in what the people in each section feel they want as basic coverage, are reflected by the different Plans in the programs they offer and their cost.

Because of this arrangement individual Blue Cross Plans have been able to include the major part of each community as members. As the membership has grown, so has the interest of the industries in the various communities. Almost every industry makes the prepayment hospitalization Plan available to its employees.

In many instances it is one of the "fringe benefits" in the Labor-Management contracts. The manage-

ment agrees to pay the employee's subscription to Blue Cross. If this type of contract does not exist then Management usually agrees to deduct the employee's Blue Cross subscription from his salary and pay it directly. While these systems have proved very successful at times a stumbling block has been encountered. Often an employer will have men working outside the area of one particular Blue Cross Plan.

In answer to this problem Blue Cross has established three different solutions.

A.) *The Inter-Plan Service Benefit Bank* is a reciprocal program for providing service benefits to subscribers of one participating Plan when hospitalized in a Member Hospital located in the area served by another participating Plan.

B.) *The Inter Plan Transfer Agreement* is a reciprocal program under which subscribers moving to the area of another participating Plan may transfer their membership.

C.) *Health Service, Inc.* is the national enrollment agency for Blue Cross Plans. It is empowered to contract with national firms for the provision of Blue Cross benefits. Such contracts provide uniform rates, benefits and enrollment and bill procedures on any given national account.

The latter, although not yet country-wide, is designed specifically for national accounts, while the first two are more for those who either are traveling or have moved.

Woman's Auxiliary to the Medical and Chirurgical Faculty

THE AUXILIARY AND NURSE RECRUITMENT

MRS. HARRY M. ROBINSON, JR.*

The Woman's Auxiliary to the Medical and Chirurgical Faculty has made a real beginning on its Nurse Recruitment Program. For instance, The Auxiliary to the Baltimore County Medical Association has not only established one student nurse in training, but is now starting a second. The Prince George's County Auxiliary has also successfully raised funds to educate a nurse. Auxiliaries to the Montgomery and Washington County Medical Societies are at the moment in the process of establishing scholarship funds.

On the state level, the Nursing Committee of The Woman's Auxiliary to the Medical and Chirurgical Faculty has been at work. A "Nurses Day" Tea was given by the Nursing Committee on Florence Nightingale's Birthday, May 12th, at The Medical and Chirurgical Faculty Building, in Baltimore, in honor of the nursing profession. The presidents of the four Auxiliaries which already have, or are establishing, nursing scholarships, Baltimore County, Prince George's, Montgomery, and Washington, acted as hostesses. Our honored guests were the President of the Maryland State Nurse's Association, the Presidents of the Nursing Alumnae Associations and the Deans and Directors of the Nursing Schools. Student government Presidents from the Nursing Schools were asked to pour. The movie, "Girls in White" was shown as a Nurse Recruitment aid.

In initiating a Nurse Recruitment Program it is important for your Auxiliary to first obtain the support of your Medical Society and to check with them on nursing needs. They will welcome any help, however small, in meeting the nationwide shortage of nurses.

☛ Auxiliary members who are active in this endeavor should become familiar with the various schools of

nursing in the state. The directors of these schools should be interviewed and their cooperation sought. Auxiliary Nursing Committees should be familiar with the courses of training offered by the various schools in their locality and the number of students that can be accommodated in each of them. Some of the schools in this state have an educational program whereby a nurse can obtain a diploma after three years of training, whereas other schools offer a Bachelor of Science in Nursing after a four or five year course.

The best time to create interest in nursing is during a student's first and second year in high school before her final curriculum is chosen and while an opportunity exists to elect the necessary pre-nursing courses. The career of nursing should be presented as an attractive one and the desire to serve one's fellow man stimulated. We suggest that the principal of your high school be interested in this program and that he give your Auxiliary permission to have suitable speakers address the student body on nursing as a career. The speakers whom we select should be of high standing in the community, capable of presenting the subject in an interesting manner, and dedicated to the ideal of service to humanity. Outstanding physicians and older graduate nurses serve well in this capacity. They should be thoroughly briefed on our Auxiliary program before addressing the student however.

The excellent moving picture "Girls in White" is available from the American Hospital Association, 18 East Division St., Chicago 10, Ill. It is available in the 16 mm version (black and white sound, R. K. O. Pathe) for the average school showing or in 35 mm version for theatre showing. The cost for this film is \$4.00 for the first 3 days plus return postage. This film has been reviewed by our Auxiliary Nursing Committee and is highly recommended by them.

Good newspaper publicity will help your nurse recruitment efforts. The editor of your paper can best cooperate by writing up your scholarship and

* Chairman, Nurse Recruitment.

program events, and by running a series of articles on nursing as a career. He could print stories of famous women who have contributed so much to humanity by adopting this branch of medical science as a profession on Florence Nightingale's birthday.

If it is not possible for your Auxiliary to establish a scholarship fund perhaps you might consider a long term loan to be repaid without interest after graduation. These are matters which must be handled by the component Auxiliaries, as their finances dictate.

There is an effective radio program on nursing as a career in operation at the present time and students in your high school should be encouraged to listen to it. Again, the editor of your local newspaper can help by publishing the name of the station and the time when these programs can be heard. This should be done in a separate place in the paper where it will attract attention.

On or about May 12, which is Florence Nightingale's birthday, your local society could give a tea and invite all of the nurses in your locality to attend in uniform. Also invite the girls in the senior high school to attend this function. Some simple program should be arranged featuring the highlights of Miss Nightingale's life.

Encourage the formation of Future Nurse's Clubs in the senior high schools of your community. The club could meet twice each month during the school year and offer a program calculated to arouse interest in nursing as a profession. Local physicians, nurses, public health officers, and teachers from some of the training schools may serve as speakers. The girls, aided by a graduate nurse, may act out skits on some of the phases of nursing life. This would also be an excellent chance for the girls to learn personal hygiene and some of the simple rules basic to good health.

An essay contest on "Why I Want to be a Nurse" with a prize of some small amount of money would be an excellent way to stimulate interest among the girls in the senior high school class. This could be done with the cooperation of the principal, having as judges one of the local physicians and a nurse. Ask the editor of your local paper to publish the best one in a prominent place in his paper.

The State Auxiliary believes that the local Auxiliaries should initiate their own programs and consult the State Nurses Association only in an advisory capacity.

Our National Auxiliary, The Woman's Auxiliary to the A.M.A., is a member of the Committee on Careers in Nursing sponsored by the American Nurses Association. This organization has published a series of pamphlets which should be placed in physicians offices, schools, public libraries, and churches.

This is an Auxiliary responsibility, and the success or failure of the program depends on the effort we apply to it. The attempt to undermine our entire structure of free enterprise by the forces which advocate socialized medicine is constant. We do not want government subsidy, but must stand on our own feet. Let us endeavor to make a success of this task, and thereby improve the health of the community at large. It can be done!

"TODAY'S HEALTH"*

MRS. ELDRIDGE H. WOLFF, *Chairman*

"Today's Health," formerly called "Hygeia," is a twenty-eight year old magazine published by the American Medical Association in the interest of better health. Because so many "health" articles by self-styled, "experts" appear in current publications, it is most important that the lay public read this scientifically accurate health magazine.

Since there are two million persons *monthly* in doctor's offices, the American Medical Association stresses the great value of having copies of "Today's Health" in the office of every doctor. That is why "Today's Health" is sold to doctors and to the Woman's Auxiliary at half price. Does your husband subscribe?

This attractive magazine deals with the simple but fundamental health principles which affect our daily lives. It prints only carefully authenticated information about health and gives reliable information on quacks, faddists and cultists.

Cooperation with the medical profession is encouraged and each article emphasizes our Dependence upon *The Family Physician*.

"DOCTOR'S DAY" PROCLAIMED

Due to the efforts of Mrs. E. Paul Knotts, our "Doctor's Day" Chairman, Governor Theodore R.

* The A.M.A. Health Magazine.

McKeldin, this year proclaimed March 30th, to be "Doctor's Day" in Maryland. He presented his proclamation to Dr. J. Albert Chatard, who represented the Medical and Chirurgical Faculty. Television and still pictures of the Governor and Dr. Chatard were taken against a background of Auxiliary members. Dr. Chatard is the ideal representative of the Faculty which he has served so long and so well, and the Auxiliary was very proud to have him as "The Doctor" on "Doctor's Day." Newspaper publicity stressed the public health protection offered by the various Committees of the Medical and Chirurgical Faculty and the failure of the public to avail itself of the authentic information offered. Doctor E. Paul Knotts, as "Family Doctor of the Year," was written up on "Doctor's Day" in the "Sun" newspaper.

The "Doctor's Day" Proclamation reads, "whereas, our State and Nation owes a great debt to those unselfish physicians who labor long hours to care for our sick and who are constantly engaged in research to prevent human misery and suffering and

"Whereas, it is fit that we should from time to time pay tribute to those unselfish individuals who guard the health of our Nation,

"Now, therefore, I, Theodore R. McKeldin, Governor of the State of Maryland, do hereby proclaim Sunday March 30th, 1952, as "Doctor's Day" and do call upon all citizens of this State to remember their Physicians on that day and in some way express their appreciation to these guardians of the Nations health."

* * * * *

REGISTER AND VOTE

in the coming Presidential Election

HELP TO GET OUT THE VOTE

Baby-sit for voting mothers, drive people to the polls. This is the least the Auxiliary can do.

* * * * *

A HELP TO YOUR HUSBAND

One of our members, after consulting her husband, sent for the A.M.A. plaque for doctors offices, which

is a Public Relations Aid. Although neither she nor her husband felt that such a sign was "necessary" they are happily surprised at the favorable comment of patients ever since it has been posted in his office! It says "To All My Patients—I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly mutual understanding between doctor and patient." These plaques are one dollar (\$1.00) from the A.M.A., 535 North Dearborn Street, Chicago 10, Illinois.

QUOTABLE QUOTES

In America—"our progress came from an economic system—that grew out of a political philosophy—which came from a religious faith which put first the dignity and worth of individual man as a spiritual being, because he is a son of God.

"Most of us in American seem preoccupied with trying to preserve the material results which came from the Judeo Christian Concept of the nature of man. A more fundamental thing is to pay attention to the spiritual causes.

"You say "What can I do?" "Why isn't it" "the thing" for good people to work in politics? More of you have to be willing to be candidates yourselves and to let your husbands be candidates for public office."

The Honorable Walter H. Judd, M.D., Representative for Minnesota—in speech to National Auxiliary.

AUXILIARY NEWS

The Woman's Auxiliary to the Baltimore City Medical Society has elected new officers, they are, *President*, Mrs. Albert E. Goldstein; *President-Elect*, Mrs. Thomas Webster; *First Vice-President*, Mrs. E. Roderick Shipley; *Second Vice-President*, Mrs. J. Arthur York; *Recording Secretary*, Mrs. Homer Todd; *Corresponding Secretary*, Mrs. Ellsworth Cook; *Treasurer*, Mrs. Harry C. Bowie; *Parliamentarian*, Mrs. Howard M. Kern; *Assistant Parliamentarian*, Mrs. J. Frank Hewitt.

THE BALTIMORE COUNTY AUXILIARYS'

"Doctor's Day" Dance, which raised funds for a second Nursing Scholarship was such a social success that some of the doctors have suggested holding another in the Fall. Congratulations!

The newly elected officers of the Woman's Auxiliary to the WASHINGTON COUNTY MEDICAL SOCIETY, are: *President*, Mrs. S. R. Wells; *Presi-*

dent-Elect and *First Vice-President*, Mrs. Gerald W. LeVan; *Second Vice-President*, Mrs. John H. Hornbaker; *Recording Secretary*, Mrs. J. G. Warden; *Corresponding Secretary*, Mrs. O. D. Sprecher; *Treasurer*, Mrs. John A. Moran; *Parliamentarian*, Mrs. Sidney Novenstein. Washington County held a very fine program on Civil Defense on April 22nd.

FEDERAL, STATE MEDICAL STOCKPILES MAY EXCEED \$80 MILLION BY MID-YEAR

Capitol Clinic, A. M. A., Vol. 3, No. 13, April 1, 1952

Latest Civil Defense Administration figures indicate total federal and state stockpiles of medical supplies on hand or on order by July 1 may amount to \$80.5 million. Of this, CDA has committed nearly all of the \$50 million voted by Congress for exclusively *federal regional stockpiles*. In addition, CDA already has given states \$10.5 million which they in turn have matched on a 50-50 basis for *local supplies*. CDA has on hand about \$9.5 million from the original matching fund appropriation which Congress has said may be used for the *Federal* stockpile, provided it's committed by June 30.

CDA explains it has the \$9.5 million left over because (a) five states containing critical target areas are not yet participating in the federal-state program, (b) market prices of some supplies have dropped, effecting savings, and (c) additional savings were achieved through simplification of specifications of some items. The states that did not join in the program by the March 15 deadline are Alabama, Georgia, Texas, Louisiana and Illinois.

Civil Defense Administrator Millard Caldwell, meanwhile, had informed Chairman Brien McMahon of Joint Committee on Atomic Energy that medical stockpiling is "unsatisfactory both in volume and quantities of supplies available." Caldwell estimates funds voted by Congress so far would provide enough supplies for only one week of emergency care for 2 million atomic bomb casualties.

For its fiscal 1953 program, CDA is asking Congress for \$193 million for *federal* medical stockpiling. No matching funds for *local* stockpiling are requested for next year.

Ancillary News

DENTAL SECTION

BALTIMORE CITY DENTAL SOCIETY

A. BERNARD ESKOW, D.D.S.

Journal Representative

The activity of the Baltimore City Dental Society for the month of March was a meeting held at the Medical and Chirurgical Building, at which time the guest essayist was Dr. P. Philip Gross, Associate in

Oral Surgery, Graduate School and Dental School, University of Pennsylvania. His subject was "Oral Surgery for the General Practitioner." He gave a most informative and excellent presentation.

It is also to be noted that the Executive Council of the Dental Society during the month of March went on record by way of a resolution to the Mayor and City Council, endorsing the fluoridation of the Baltimore City water supply as a means of reduction of dental caries.

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Administrator*

Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations

MARYLAND LICENSED PRACTICAL NURSES ASSOCIATION

On March 25, 1952 a new association, the Maryland Licensed Practical Nurses Association, was formed. All Maryland Licensed Practical Nurses were invited to attend the meeting to organize the new Association and a large group was present. Officers were elected and the Constitution and By-laws approved. The object of the Association as stated in its Constitution is as follows:

To associate together all licensed practical nurses in Maryland for the following purposes:

1. To cultivate, promote and disseminate knowledge and information concerning practical nursing and subjects relating thereto.
2. To establish and maintain high standards of integrity, honor and character among practical nurses.
3. To furnish information regarding practical nursing and the practice and methods thereof to its members, and to the general public with respect to the practice of practical nursing.

4. To communicate with other organizations of nurses.
5. To promote vocational and social relationships among its own members, and between its own members and the members of other organizations of nurses and persons interested in nursing or related subjects.
6. To promote the welfare and interests of practical nurses, and to advance educational standards.
7. To further the efficient care of the sick and to do all things which shall be lawful and appropriate in the furtherance of any of the purposes hereinbefore expressed.

1952 BIENNIAL NURSING CONVENTION

The 1952 Biennial Nursing Convention of the three national nursing organizations will be held in Atlantic City, New Jersey, June 16-20 inclusive. Because of the impending change in the structure of these organizations, this will undoubtedly be a historic convention.

FINANCIAL AID TO STUDENT NURSES

Recently there has been much discussion about the need for financial aid to student nurses in order to increase enrollment in schools of nursing.

The Joint Committee on Nursing Information of the Joint Board of Directors of the Three Maryland State Nursing Organizations sent questionnaires to all schools of nursing in Maryland to obtain information about the need for such aid.

Nineteen schools returned questionnaires; of these, sixteen reported scholarships available; fourteen reported loan funds available. All schools had some form of financial aid available; two schools helped students only through loans.

Eleven schools stated that they needed no more scholarship aid; some of these have scholarships which are unused because they have no needy students. Six schools expressed belief that more students would be attracted to their schools if they could offer more scholarships. One school had no scholarships, but expressed a need for additional loan funds. Two schools estimated that they would like to have from 1-3 additional scholarships. One school reported loss of five applicants since September, 1951 because of lack of scholarship aid; this school estimates a need for \$5,000 in available scholarships and loan funds. Another school estimated that about 20 out of 50 students "could use" financial help. Two schools reported need for more scholarships for higher education.

Sixty-six of the scholarships offered by the various schools were described as covering "all fees," "all expenses," or "tuition and uniforms." Fifty scholarships cover part of the school expenses. Four schools offer a total of seven scholarships to alumnae for post-graduate study.

Nine hospitals offer scholarships to students in their schools; six schools have scholarships awarded by women's auxiliary organizations; six schools have scholarships awarded by the nurses alumnae associations. Seven schools reported having scholarships from individuals and organizations which were not named. Many organizations were named by one or more schools; these included: Optimist Club, Women's Civic Club, Beta Sigma Phi Sorority, American Legion, Catholic Nurses Guild, Ladies of Moose, Hibernian Society, Women's Eastern Shore

Society, Civitan Club, Zonta Club, Lions Club, Elks Club, Bruck Uniform Company, Jessie Smith Noyes Foundation, and Cooper Foundation.

This study showed that there is widespread interest in helping worthy students obtain an education in nursing. The study also seems to indicate that the needs for more scholarship aid are greatest in those nursing schools which have the largest enrollment and those which are most costly to the student.

STUDENT NURSES COUNCIL OF MARYLAND

JOAN WILLIAMS, R.N., *President*

On the 5th of March, 1952, approximately 200 student nurses representing eighteen of the twenty-one professional schools of nursing in Maryland met in Baltimore and organized the Student Nurses Council of Maryland. This Council was first started in June 1951 when the student nurses in District No. 2 of the Maryland State Nurses Association began making plans for an organization on a District level. However, in November permission was granted for the student nurses of Maryland to begin organizing on a State level with the Three Maryland State Nursing Organizations as their sponsors.

At the Mass Meeting on the 5th of March the Constitution and By-laws, which had been previously created, were approved unanimously. The election of officers was held and the results were as follows:

President, Joan Williams of Johns Hopkins; Vice-President, Barbara Matheny of Union Memorial; Recording Secretary, Peg Brown of University; Corresponding Secretary, Joanne Duffy of Mercy; and Treasurer, Bill Aikens of St. Agnes. These students, all of whom have been very active in helping to organize the Council, will hold office until May 1953.

The first step which has been taken was to have each school of nursing elect one representative to serve on the Board of Directors. A meeting of the Board of Directors is being called in the near future to discuss plans for a Florence Nightingale Service to be held during the first part of May. It is hoped that when the Membership Committee is set up, a 100% membership will be obtained from each school of nursing.

MEETING OF THE AMERICAN MEDICAL ASSOCIATION

June 9 to 13, 1952, Chicago, Illinois

Registration: Navy Pier, at the foot of Grand Avenue

Meetings

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

MATERNAL MORTALITY MEETING

Thursday, June 26, 1952, 4:00 p.m.

Joint Committee on Maternal Mortality of the Baltimore City Medical Society and the Baltimore City Health Department.

THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman* BEVERLEY C. COMPTON, M.D., *Secretary*

Thursday, June 19, 1952

5:00 to 6:00 p.m.

VACCINATIONS FOR INTERNATIONAL TRAVEL

The tourist season is (along with spring) just around the corner. You and your family may have planned a foreign trip this summer. Even if you haven't some of your patients will have, and you will be called upon to administer the list of vaccinations required of travelers heading for one of the 132 countries and territories in the world.

You may secure this list from:

The Pan American Sanitary Bureau
The Regional Office of World Health Organization
1501 New Hampshire Avenue, N. W. Washington 6, D. C.

Vaccinations most generally required are against smallpox, yellow fever, and cholera, although several countries also insist on inoculation against typhoid and paratyphoid fevers, typhus, diphtheria and tetanus.

* * * *

VOLUNTARY INSURANCE

Council News, Research Council for Economic Security
Vol. II, No. 3, March, 1952

Voluntary Insurance has met almost one-third of the cost of the nation's hospital bill and one-eighth of the estimated cost of physicians' care. These percentages for 1950 represent a gain of almost 8 per cent and 5½ per cent, respectively, as compared with 1948 figures. In its report, "Voluntary Insurance against Sickness: 1950 Estimates," the Social Security Administration reveals that the amount of the nation's hospital bill paid through private resources came to approximately \$2¼ billion. About \$680 million of this total bill were paid from insurance funds. Blue Cross Plan payments accounted for \$378 million; commercial insurance company payments came to about \$254 million. The nation's medical care expenditures were estimated to be somewhat over \$2½ billion, of which voluntary insurance funds paid about \$312 million.

Maryland

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A MESSAGE FROM THE PRESIDENT

To the Members of the Medical and Chirurgical Faculty of the State of Maryland:

May I call your attention to the excellent statement by Dr. Herbert Notkin of the State Department of Health in reference to the Maryland County Medical Program, which appears in this issue of the JOURNAL? I hope that every member of the Faculty will take the time to read it, whether or not he or she is participating in the program, in order to become familiar with this worthwhile activity.

Having been from the very beginning a member of the Council that advises the State Department of Health in regard to this undertaking, I have had an exceptional opportunity to see from the inside how it is organized and conducted. I am very glad to have this chance to give my wholehearted endorsement not only of the program itself but also of the way those in charge have administered it.

Not all of the administrative difficulties have been ironed out as yet, and there are still areas in which the participating physicians can contribute toward improving the actual operation of the activity, as Dr. Notkin points out, but the citizens of Maryland and their representatives in the Legislature can rest assured that it is working and working very well. It deserves the support of everyone in the State and I hope that it will receive that support in full measure.

ALAN M. CHESNEY, M.D.

THE MARYLAND COUNTY MEDICAL CARE PROGRAM—A PROGRESS REPORT

HERBERT NOTKIN, M.D.*

BACKGROUND

In 1939, the Medical and Chirurgical Faculty took a long step forward in improving the medical service available to the low-income citizens of Maryland. In August of that year, Dr. Victor Cullen addressed a letter on behalf of the Faculty to the State Planning Commission pointing out the importance of setting up a permanent Medical Care Committee to study medical care problems. One of the seven major deficiencies in medical services in the state which this letter pointed out was "The lack of funds or organization for the medical care in their homes of those upon relief and for other classes of indigent patients."

On the basis of this letter, a Committee on Medical Care was appointed under the chairmanship of Dr. Maurice C. Pincoffs. This committee made an exhaustive study of the medical care problems of the indigent and medically indigent residents of the Counties of Maryland.

In 1944, the Committee reported its findings and recommendations to the annual meeting of the Medical and Chirurgical Faculty. In effect, the report suggested the provision by the state of medical care services for the indigent and medically indigent. The proposed program was to be administered by the State Department of Health within the framework of existing patterns of medical practice. The faculty unanimously approved the report.

By February of 1945, the legislation to put this recommendation into effect was passed by the General Assembly, and signed by the Governor. In June of 1945, the program began actual operation in the counties of the state under the administrative control of the Bureau of Medical Services of the State Department of Health with

local control vested in the twenty-three existing county health departments.

The program has, therefore, been in operation continuously for seven years and the State Department of Health feels that a brief report of the events of these years should be made to the medical profession, whose cooperation made the plan possible and is basic to its continuing success.

PRINCIPLES

The program operates under certain basic principles which are important to those physicians who cooperate with it. These principles are:

1. Insofar as possible, the county health departments are given freedom to adapt the program to the special conditions existing in each county.
2. Policies are based on the advice of representatives of the various professional groups participating in the program.
3. The principles of free choice of physician by the patient and the right of a doctor to accept or refuse patients are recognized.
4. Payments to physicians are made on the fee-for-service system.
5. The amount of "red tape" is kept to the absolute minimum consistent with efficient and economical administration of the program.

BENEFICIARIES

All recipients of public assistance in the Counties of Maryland are automatically eligible for medical care under the program. During any one month, approximately 25% of public welfare clients request medical care. This may seem fairly high, but it must be remembered that this group has more illness than the general population because of its composition. A large proportion of the assistance clients are aged and infirm, and many have become recipients of welfare

* Assistant Chief, Bureau of Medical Services & Hospitals, Maryland State Department of Health.

because of illness. Approximately 60% of all those receiving the benefits of the program are welfare clients.

The other 40% of those served are designated as "medically indigent." These people have a marginal income, and are normally self-supporting, but cannot afford the added expense of illness. If persons in this class become ill, they may request certification from the county health department. The primary basis for this certification is the family income. As one example, a family of four people cannot be certified for care if the income in the county with the highest income scale is more than \$121.00 per month. Since the program is administered by physicians, the department feels strongly that the health officer should be permitted to make exceptions to this income scale for medical reasons. The major reasons for such exceptions are the cost and duration of the illness, the incapacity of a wage earner, and the necessity for expensive drugs or diets. For this reason, the physician attending the patient is requested to let the health officer know the diagnosis and expected duration of the illness.

All concerned with the subject know that the determination of income is an extremely difficult task, and a certain number of errors will be made no matter how carefully the work is done. For this reason, all participating physicians are asked to assist in preventing abuse by requesting the re-investigation of any beneficiary of the program if they feel that an error has been made.

SERVICES PROVIDED

Since approximately 75% of physicians in active practice in the counties of Maryland participate in the program, the profession is aware that the program will pay for home and office calls, deliveries, and drugs, whether dispensed or prescribed. Consultant service is also supplied at the request of any physician who feels that his patient will benefit from these services. In 1951, nearly 68% of the total expenditure under

the program was for physician's services, largely for home and office calls by general practitioners.

The program also provides a limited amount of dental service, principally fillings and extractions, although a small number of dentures are also supplied. Only 5 per cent of the total cost of all services in 1951 was for dentistry.

One of the immediate concerns of the program is the fact that drug costs have been rising continuously since its inception. In 1947, only 14.5% of the cost of all services was spent for drugs. By 1951, this had increased to more than 26%. Part of this rise is due to the higher cost of prescriptions. This reflects both the increased wholesale cost of drugs and a tendency for physicians to prescribe more expensive drugs, such as antibiotics and certain vitamins. There seems to be no question that considerable savings could be effected if physicians would prescribe the U.S.P. and N.F. equivalents of expensive proprietary medications. Another reason for high drug costs is the tendency over the past few years for doctors to write more prescriptions per call. In 1947, physicians wrote approximately 45 prescriptions per 100 calls, while in 1951, this had risen to nearly 66 prescriptions per 100 calls.

The smallest phase of the program is that which provides special diagnostic services, usually in hospital outpatient departments. Despite the fact that the use of this service is encouraged wherever the doctor finds need for it, less than 2% of the total cost of the program is spent for this type of care.

POLICY DETERMINATION

Physicians are critical from time to time of various regulations of the program and it seems to be inevitable that this type of reaction should occasionally occur. If, however, doctors understand the mechanism by which policies are determined, they might be a little more tolerant toward the "bureaucrats" who administer the program. The basic law of the program sets up a State Advisory Council on Medical Care. This Council is composed of representatives of the

medical, dental, nursing, and pharmaceutical professions; the hospitals; the medical schools; and several *ex officio* members. The present membership of the group is:

Dr. Page Jett, Chairman—Medical & Chirurgical Faculty

Dr. George E. Hardy, Maryland State Dental Association

Dr. J. W. Bird, State Board of Health

Mr. Walter E. Albrecht, Maryland State Pharmaceutical Association

Miss Martha Johnson, R.N., Maryland State Nursing Association

Dr. J. Edmund Bradley, University of Maryland School of Medicine

Mr. J. Milton Patterson, Maryland State Department of Welfare (Ex Officio)

Dr. J. T. Marsh, Medical & Chirurgical Faculty

Dr. Douglass Shepperd, Maryland Medical Association

Dr. Edwin L. Crosby, The Johns Hopkins Hospital

Dr. Alan M. Chesney, The Johns Hopkins University School of Medicine

Dr. Clifford T. Perkins, Maryland State Department of Mental Hygiene (Ex Officio)

Dr. R. H. Riley, Maryland State Department of Health (Ex Officio)

This group, selected by the various professions and interests involved in the program, makes recommendations on questions of policy which are acted on by the State Board of Health, a group that also represents the professions. It is evident, therefore, that policy determination is not made by State employees, but by public spirited citizens, who are broadly representative of the professions concerned and who serve without compensation.

The State Advisory Council has urged that similar advisory committees be set up in all the counties on a local, voluntary basis. Where such committees are active, they have proven to be a most useful mechanism for preserving the necessarily close relations between the health departments and the various professions.

All decisions of local health departments or the Bureau of Medical Services and Hospitals may be appealed to the State Board of Health, which has the final authority.

PAST EXPERIENCES

New programs usually start off slowly, and then tend to increase fairly rapidly in size, as they become known in the community. This has basically been the experience of the County Medical Care Program. A few selected figures will demonstrate this fact. In 1947, there were 743 participating physicians. In 1950, a high of 900 was reached, although in 1951, this had decreased to 852. Slightly more than 15,000 patients received service in 1947. This number rose to approximately 28,000 in 1950 and dropped to less than 25,000 in 1951. The total cost of the program was \$366,000 in 1947, rose to \$718,000 in 1950, and decreased to \$661,126 in 1951. The most important single factor affecting the cost of the program is the number of people receiving public assistance from the various county welfare departments. The high cost of the program in 1950 reflected a temporary wave of unemployment. Conversely, the decreasing costs and number of beneficiaries in 1951 are a reflection of the generally improving economic situation.

THE FUTURE

No one can predict with accuracy the long-range future of the program. It has apparently gained general acceptance with both the physicians in Maryland and the recipients of the service. It has, however, been attacked by a number of members of the General Assembly on the following counts:

1. That many of those who obtain service under the program can actually afford to pay for their own care. The State Health Department is always aware of this possibility, but believes that within the limits of human error, certification of ineligible people is being kept to a minimum.
2. That many beneficiaries of the program "shop" from doctor to doctor until they obtain the particular service or prescription that they desire. Although this is a distinct possibility and undoubtedly happens in

some cases, neither practicing physicians or health officers believe that it is a common occurrence. It is difficult to prevent this abuse as it exists at present without possible interference with free choice of physician.

3. That some doctors render unnecessary services under the program and profit at the expense of the State. Unfortunately, this is sometimes true and steps are being taken to minimize the misuse of the program. The problem is, however, limited to a very few physicians.

These reasons were given to explain the fact that the 1952 session of the General Assembly cut the already modest budget request by \$50,000. In effect, the program will have \$112,000 less for operating expenditures for the fiscal year beginning July 1, 1952 than it has for this year. If welfare loads stay at the October, 1951 level for the next fiscal year, the program can expect a deficit of approximately \$50,000. Any turn for the worse in the economic situation or any epidemic will markedly increase the expected deficit.

Unless marked economies can be effected in the program, the only way to live within the budget is to prorate payments to professional participants. According to existing policy, proration is mandatory to a maximum of 70% of billings, if any one month's bills exceed the allocation of funds for that month.

THE NEED FOR ECONOMY

What can physicians do to keep down the costs of the program? A number of suggestions are listed below. If these suggestions are followed generally by participating physicians, it may be possible to keep the expenditures of the program within the limits of the appropriation.

1. Whenever possible, with equal benefit of the patient, write the U.S.P. or N.F. equivalent of expensive proprietary medications.

One example of this is to prescribe phenobarbital, U.S.P. instead of "Luminal".

2. Prescribe drugs in limited quantities, if this can be done without increasing the number of calls. This is particularly true in the high cost antibiotics which frequently work so rapidly in acute infections that fairly large amounts of the drug are left over when the patient is better.
3. Avoid prescribing expensive vitamins or other expensive drugs as placebos or tonics.
4. Write as few prescriptions as possible. If physicians wrote an average of 45 prescriptions per 100 calls in 1947, it is not easy to see why they had to write more than 65 prescriptions per 100 calls in 1951.
5. Teach patients, particularly those with long-term illnesses, to limit their calls.
6. Teach patients to request home calls only when they cannot make office calls. Some physicians have obviously been successful in this endeavor, while others apparently make no effort to do so as is demonstrated by the fact that some physicians make more than 80% of their calls at home, compared to a State-wide average of approximately 30%.
7. If you believe that an individual has unjustly received a medical care card, notify your local health officer, so that he may have the patient reinvestigated.

CONCLUSION

The State Department of Health sincerely believes that the County Medical Care Program has proven its value to low-income citizens of Maryland and to the medical profession. If the department and the practicing physicians cooperate, it may be possible to live within the legislative appropriation for next year without proration and to help insure the existence of the program in the future.

BUILDING CLOSED

INDEPENDENCE DAY, FRIDAY, JULY 4, 1952

Reports

COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D., *Secretary*

The Committee for the Study of Pelvic Cancer held its regular monthly meeting at 5 P.M. on Thursday, April 17th in the Small Hall of the Medical and Chirurgical Faculty Building.

CASE DISCUSSIONS

CASE I. R. S. Colored. Age 33 years. Married. Para 1. Yellow vaginal discharge beginning about 1949. Periods regular. No intermenstrual bleeding noted until January 1951. Consulted doctor A about April 1950 because of G.I. symptoms and vaginal discharge. Was examined—given a series of six “table treatments.” Continued to consult doctor A over several months. As she felt she was not improving went to the hospital clinic February 7, 1951. (Had been seen in the medical clinic of the hospital in January and July 1950.) *Diagnosis:* Squamous cell carcinoma of cervix, Clinical Stage I. Radium. Radical Wertheim.

Guest physician: This patient first came to me in April of 1950 giving a history of a series of complaints. She stated that she had been treated previously in the Medical Clinic at the hospital and had had a psychiatric consultation. My physical examination showed nothing remarkable. She returned to my office a week later stating that she felt better than she had felt in a long time. She was seen again in August of 1950 complaining of leucorrhea and the examination showed Trichomonas. She was treated for this and got along very nicely. She returned on November 27th complaining of some abdominal pain. General physical examination was essentially negative. She was seen again on January 1st, 1951, with the complaint of an upset stomach and hot flashes. General physical examination, including blood counts, showed nothing remarkable. When seen on January 16th she complained of epigastric pain and was referred for an x-ray examination. At no time was there a complaint of any vaginal bleeding.

Chairman: Thank you very much for coming to this meeting today and presenting this history.

I presume that you used a speculum in examining this patient, before treating her for the Trichomonas. Did the cervix appear entirely normal at this time?

Guest physician: Yes. There was nothing suspicious.

Chairman: This patient was classified as carcinoma of the cervix, Stage I, received radium and then had a radical Wertheim operation. Is this the usual routine at this hospital?

Committee member: Yes, in selected cases.

Visiting surgeon: How long do you wait after radium therapy before operation?

Committee member: We usually wait from four to six weeks. In this particular case the patient received 4500 mgm. hours of radium on March 13th and was operated on the 23rd of April.

Committee member: Of course, this treatment is in a fluid stage. I believe Meigs prefers not to use radium if the patient is to be operated on.

There was considerable discussion of this point and some discussion of individual cases.

CASE II. L. B. Colored. Age 50 years. Single. Menopause in 1947. Beginning late in November 1951, crampy pain in R. L. Q., intermittent. Consulted doctor A in December 1951—pelvic examination not made—patient given medicine which relieved the pain temporarily. Consulted doctor A several times during December and January. Late January, bloody vaginal discharge. The patient states that she was not examined until she told doctor A that she felt she had not been adequately examined. Examined February 4, 1952, told that she had a tumor and referred immediately to the hospital. *Diagnosis:* Carcinoma of ovary, with peritoneal and liver metastases. Exploratory laparotomy; subtotal abdominal hysterectomy; bilateral salpingo-oophorectomy. X-ray.

Chairman: It is remarkable how frequently we hear stories similar to this, where the patient was not given a pelvic examination until she requested it. Is there any discussion of this case?

Visiting surgeon: There is not much to say about

this case. By the time she came into the hospital the situation was pretty hopeless. During the course of her x-ray treatment she had a pulmonary embolus and died.

Chairman: From the information we have it would seem that there was some physician delay here. The patient consulted her physician in December complaining of crampy lower abdominal pain and, although she consulted the physician several times, was not examined until early February.

CASE III. C. C. White. Married. Para 1 (stillborn). Age 29 years. Beginning about October 1950, vaginal bleeding almost daily and post-coital bleeding. Consulted doctor A—was not examined—pills prescribed which checked the bleeding for about three months. When bleeding recurred consulted doctor A again—was not examined—capsules prescribed, with improvement for a short time. Patient told she should go to the hospital if bleeding continued. Following the next menstrual period bleeding became continuous. Patient went to hospital clinic March 3, 1951, and was hospitalized. *Diagnosis:* Immature squamous cell carcinoma of cervix, Stage I. Wertheim operation. Post-operatively patient developed a ureteral-vaginal, vesico-vaginal fistula. July 1951, left ureter re-implanted into bladder to correct fistula—followed by persistent urinary tract infection. January 7, 1952, re-admitted to hospital with complaint of acute abdominal pain. Operation: Pyelostomy, left.

Chairman: Those not very enthusiastic about surgery have a case here. It is an interesting case and I am sorry none of the hospital staff could be present today.

Committee member: I would like to ask a question. Who has done the most harm, Meigs or Brunschwig?

This question provoked a long discussion concerning the theories and techniques of the two men.

Chairman: As to the case we have under discussion, the patient certainly should have had a pelvic examination earlier, particularly with the complaint of post-coital bleeding.

CASE IV. R. C. White. Age 55 years. Widow. Para 3. Menopause 1939. Given pills and "needles" for menopausal symptoms. Menses returned once, March 1944. No further bleeding until February 1951 when patient began to have intermittent staining. Beginning about October 1951, irregular vaginal bleeding. Patient was under care of doctor A for a heart condition and diabetes. Told him of the staining about March 1951. Patient not examined but told she would be referred to a specialist. Saw a specialist in January 1952. Consulted doctor B January 7th and was hospitalized January 14th. D. & C. and biopsy January 22nd. Pathological report revealed endometrial hyperplasia and chronic cervicitis. Discharged from hospital January 24th. Recurrence of vaginal

bleeding February 24th. Review of slides from biopsy of January 22nd revealed suspicion of malignancy of endometrial tissue. Patient re-admitted to hospital for radium therapy March 10th. *Diagnosis:* Carcinoma of the endometrium. Radium. (Patient considered a poor risk for surgery.)

Visiting surgeon: The original pathological report was endometrial hyperplasia and chronic cervicitis, as given on the abstract. At this hospital the slides are reviewed once a month for the house staff, and in going over this slide the question of malignancy was raised, with the possible diagnoses varying greatly. It was decided to bring the patient back into the hospital for a diagnostic D. & C. and an insertion of radium. She is a bad cardiac and too poor a risk for surgery.

The question now is how best to follow this patient. Follow with a curettage in six months? Follow with Papinicolaou smears and a subsequent curettage, if necessary?

Committee member: I believe that the general feeling is that smears are useless following radium treatment; positive or negative does not seem to mean a thing.

Chairman: I believe I would do a D. & C. six months after the radium therapy. I believe it would be safe from a practical standpoint. How much radium was used in this case?

Visiting surgeon: 6000 mgm. hours.

There was a discussion of the increase in complications following the larger dose of radium.

CASE V. E. W. Colored. Age 29 years. Married. Para 0. Menses irregular and increasingly profuse for the past nine years. At first, profuse bleeding for 6-7 days, gradually increasing until periods lasted 10-17 days with heavy bleeding, flooding and clots. August 2, 1951 very profuse bleeding which continued until time of hospitalization September 24, 1951. Patient states that she has been under care of doctor A since profuse bleeding first started nine years ago. She was examined once, six years ago. Consulted physician whenever bleeding was profuse and was given "needles" to control the bleeding. Was told in August 1951 that she had a "tumor of the womb." Referred to hospital September 22, 1951. *Diagnosis:* Epidermoid carcinoma, cervix uteri. Modified Wertheim. X-ray.

Visiting surgeon: When this patient was first seen in the clinic she had a tumor mass well beyond the umbilicus. The cervix looked clean. Schiller's test was negative. The biopsy taken at this time was reported as intraepithelial carcinoma, but the sections showed invasive carcinoma well into the stroma.

Chairman: In this case the operation was started before the pathological report was received. This, of course, was a mistake. If the report had been known pre-operatively a conization would have been done and probably the patient would have been treated with radium rather than surgery. The operation had not progressed very far before the report was received and although the operation was extended to remove more parametrium it was not a typical modified Wertheim hysterectomy.

Committee member: What would you do about the fibroid if the patient had been treated with radium?

There was discussion of this point but the con-

sensus was that it would be safe to wait and see if there was bleeding after irradiation. If the fibroid was asymptomatic it could be left alone.

STATISTICS

Patients Interviewed to April 1, 1952.	136
<i>Classification:</i>	
Patient Delay.	63
No Delay.	40
Physician Delay.	14
Patient and Physician Delay.	6
Institutional Delay.	3
Patient and Institutional Delay.	2
Asymptomatic Detected Cases.	8

THE DOCTOR-CITIZEN IN 1952

WHITMER B. FIROR, M.D.*

The Maryland State Medical Journal has impo-
rtuned you and your family to vote in this
crucial year, and has emphasized registration as a
prerequisite for this right and duty of every citizen.
The necessity for such action is indicated by a
report in the Ohio State Medical Journal¹, following
examination of the voting records in the 1948
elections in Summit County, Ohio, which includes
Akron and is considered characteristic of pivotal
states which decided the outcome by a very narrow
margin. This report follows:

	Did not vote	Not registered
Physicians.	18%	13%
Physicians' wives.	22%	16%
Members of Rotary & Ki- wanis Clubs.	10%	8%
Druggists.	18%	15%
Teachers.	11%	6%
Bank employees.	32%	26%
Ministers.	33%	26%
Retail grocers.	34%	29%
Members of Chamber of Commerce.	21%	15%

The significance of this report is painfully evident.

Correlated with the urgency to exercise your
right to the franchise is a consideration of values
with regard to respective candidates. Suggestions

* Member, Committee on Public Medical Education, Bal-
timore City Medical Society. Chairman, Speakers Bureau,
Medical Care Campaign Committee of the Faculty.

which are to be made below for discussion with your
friends and patients, who are also your friends
when you practice your profession skillfully and
considerately, do not necessarily reflect the position
of your local society nor that of the Medical and
Chirurgical Faculty of the State of Maryland.
Though they may be at variance with your ideas,
I hope that you will be charitable enough to give
them some thought.

Our profession is concerned chiefly with the
position of any candidate on the issue of compulsory
health insurance or socialized medicine as opposed
to support of the expanding voluntary plans. A
candidate who claims that compulsory insurance is
not socialized medicine is misinformed, misguided,
socialistic, or thinks it politically expedient to be its
advocate. A thorough study of this plan indicates
that anyone who supports it wants to force the
American people to pay at least six per cent of their
income in taxes in order to feel worse than they do
now! No well-informed and conscientious person,
professional or lay, could vote for such a candidate.

As citizens we should also be opposed to ruinous
socialistic ventures on the part of the Federal
government with regard to educational institutions,
farmers, and others engaged in productive endeavor.
An acceptable candidate should be one who believes
in restoring a great measure of self-reliance to the

people; believes that the solution of most domestic social and economic problems is more likely of success when it is sought through local government rather than the dangerous intermediation of paralyzing bureaucrats in a huge centralized State; believes in the spiritual content of the American Dream as the only weapon which can overcome the "historic materialism" of the Marxists permanently. Candidates who have supported or do support much of the Federal program in domestic affairs are very suspect, to say the least. Those who have been "all out" in such support endanger the personal liberty of everyone, would render the pursuit of happiness futile, and reduce life to a dull physiological process if their warped ideas were to prevail.

Taxation and inflation constitute an issue on which the greatest unity of action is probable. Abundant evidence exists that excessive government spending and an unbalanced budget are the chief inflationary factors in our economy. Colin Clark², an eminent Australian economist, who has investigated the effect of taxation in Western Europe and Great Britain since World War I has found that taxes above 25% of national income have consistently resulted in inflation. Although he does not consider this evidence conclusive, he thinks it very significant. The effect on production he describes as follows: "Many people don't find it worth their while to work hard and efficiently. Production doesn't expand as fast as it should. There is a shortage of goods followed by an inflationary rise in prices." Federal, state and local taxes now total 33% of our income³—this with an unbalanced budget in a country whose government has spent \$81 billion more in the last six years than was spent in the entire history of our nation to the end of World War II! It can be pointed out that insurance policies and social security benefits are much reduced in value, and that expansion of the latter would require still greater taxation which, in time, would produce still greater reduction in value. An acceptable candidate, therefore, knowing that solvency is indispensable to strength should have a clear idea as to how to reduce taxes, improve our productivity, and balance the budget. Our friends above the St. Lawrence have set us a fine example in this regard.

An acceptable candidate will recognize the responsibility of labor as well as that of management

where the public interest is involved. The financially unembarrassed labor leader, more concerned with developing and maintaining personal power than the good of the workers and their country, has replaced the greedy manager of many years ago as a public enemy. Some means must be found to curb his monopolistic practices and adherence to the Marxian dialectic.

All the candidates will assert, on questioning, that they are against corruption. An acceptable candidate, however, will be merciless in his attack on our lack of morals in government and will be able to demonstrate his conviction that "public office is a public trust" by the company he keeps and his plan of procedure.

This nation, still the strongest in the history of mankind, has acquired leadership in world affairs which clearly points up the necessity of a forthright, daring foreign policy based on the knowledge that Marxism and freedom cannot co-exist. A candidate worthy of the confidence of a free people will have to formulate a policy in which the United States seizes the initiative in contradistinction to the half-hearted, relatively ineffective and weak attitude of recent years. It will require imagination and the sort of inspiration which emanates from belief in a natural moral law, referred to by the majority as an expression of God. It becomes, in essence, a conflict between the spiritual and material. Only the most outstanding of men will be able to cope with it victoriously and still maintain our solvency and strength. This is no time for "stuffed shirts", party hacks, or some housewives' television heroes. There are those among us who can restore the Congress as the great instrument of a great people. There is someone among us who respects the Constitution of the United States, who will be President of all rather than the sycophant of a special group.

Many people have fought and died in order that you and I might be free. In this election year it is incumbent upon us to fight for freedom with the ballot, to revitalize the American Idea.

Practical suggestions to provide a better world for our children and grandchildren are to:

1. Register, if you haven't.
2. Promulgate ideas against big government, insolvency, socialistic trends.

3. Support groups, professional and lay, who have similar ideas.
4. Permit nothing to prevent your voting. (Emergencies don't take twelve hours and elective procedures should not interfere.)
5. Do everything possible to see that your family, friends, and neighbors vote.

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THINK OF THIS!

Contributed by D. L. Reimann, M.D.

The Doctor should possess:—

"The art of detachment.
The virtue of method.
The quality of thoroughness.
The grace of humility."

SIR WILLIAM OSLER

ELI LILLY AND COMPANY AIDS FLOOD VICTIMS

Eli Lilly and Company, in accordance with its long-established policy, is replacing all Lilly products in pharmacies and hospitals ravaged by the flood in the Missouri and Mississippi River Valleys. Lilly representatives in a dozen states, from Montana to Missouri, have been directed to make the replacement of flood-damaged Lilly pharmaceuticals and biologicals their first order of business. Eli Lilly and Company has been replacing stocks damaged by uninsurable hazards as far back as the 1906 San Francisco disaster.

Along with the replacement of stocks, the Lilly company maintains a reserve supply of typhoid vaccine and other biological products which is kept ready for fast shipment during disasters. The shipping personnel of the company stands by twenty-four hours a day.

As the flood waters recede, the replacement of normal stocks will be made as fast as drug stores, hospitals, and wholesale druggists reopen their doors. In the event of a threat of an epidemic, however, needed drugs are shipped directly to the affected area by the fastest possible means of transportation.

SUMMER HOURS FOR THE FACULTY BUILDING

June 16, 1952 to October 1, 1952

Monday through Friday—9 a.m. to 5 p.m.

Saturday—9 a.m. to 1 p.m.

Scientific Papers

SALT¹

LOUIS KRAUSE, M.D.

"Let your speech be alway with grace, seasoned with salt, that ye may know how ye ought to answer every man" (Col. 4:6).

Little did I expect to be so impressed with the great salt domes, or deposits, in Southeast Arabia.

Leaving our dig of the ancient capital Kataban, we followed along the Wadi Beihan for twenty five miles. Then, turning inland seven and a half miles, we suddenly saw looming across the horizon, above the sand dunes, a great hill that proved to be crystalline salt. It was sundown when we reached the domes; purple haze and changing light added greater mystery to them. These deposits have been referred to by various travellers for generations, yet no one records having visited them in recent history. They are solid masses of salt, just ordinary table salt almost crystalline, and have for millenia supplied salt to this part of the world.

A few natives received us with the usual desert formality, namely, the firing of rifles by the welcoming party. Their formal custom of greeting is kissing and handshaking. The natives kiss each cheek of those with whom they are familiar, but with a stranger, the greeting is a handshake and the production of a sucking noise resembling the sound of a kiss. Actually they are kissing the air and one is expected to do the same in return. The tribesmen kiss the

back of the hand of the sheik, sometimes the hem of his garment. The manner of speech of these cameleers was especially interesting to me. They spoke just above a whisper, with many gestures, sometimes replacing their words entirely with signs.

These caravaneers come over long desert routes every few days and chop away enough salt for twenty-five or thirty camels to carry back to the centers of distribution. A large camel can carry 420 pounds of salt and the smaller ones 360 pounds. The salt is carried in two cylindrically shaped sacks equally weighted and placed on each side of the camels hump.

These bedouin are an extremely simple and trustful people. We were completely in their hands and yet I feel they would have defended us against trouble, with their lives.

As we were sitting about the camp fire, after finishing our meal of mutton and millet bread, we were greeted by singing. Eleven of the tribesmen aligned themselves about 1000 feet from the camp fire and began to chant. After the first stanza, half of their number chanting, proceeded toward us about a dozen paces; when this group finished singing, the remaining half, passed the first group by approximately six steps, then halted. Thereupon the original half began chanting another stanza, marched toward us and passed the second group. This was continued until they were within a few paces of our camp fire where all, still singing, rejoined into a single row. Their song is usually an improvised one, relating to the goodness of the sheik of the tribe, the generosity of the land and may possibly contain a few complaints. This singing is the

¹ In 1950, Dr. Krause participated in an expedition to the "land of the Queen of Sheba." An exploration trip to the great salt domes at Aiyadim, in South Central Arabia, inspired this article. Preceding his trip there is no record in recent history of non-Arabs having ever visited the Salt Domes.

typical antiphonal type, except for an occasional accompaniment of a percussion instrument, the greater portion is a cappella. The instrument used resembles a drum and is made by drawing a skin over a piece of bent palm wood, or tin.

After finishing their song the natives went back to their camp fire. This left us to ponder over the pages of history that were written in this part of the world, in particular the desert customs and religious practices that have influenced our Bible.

The following morning we carefully observed the salt deposits. This geological phenomenon is the result of pressure exerted by the ocean bottom upon its deposits of salt. The salt is forced upward through the crust of the earth, and since it is more labile than the heavier deposits in the earth's magma, it appears above the earth's surface as a dome, or truncated cone. These projections, or domes are usually multiple and have been serving salt to this part of the world for countless centuries.

Salt must have been practically unattainable to primitive man in many parts of the world. The inland people felt that a salt spring was a special gift of the Gods. The Germans waged war for saline streams, believing that the presence of salt in the soil gave the district a special sanctity. It was considered a sacred place where their prayers were heard most readily. The Gods were worshipped as the givers of the fruits of the earth, and, as "salt and bread" go together in common use, salt was always associated with offerings, especially those which consisted of cereal elements, "And every meal-offering of thine shalt thou season with salt; neither shalt thou suffer the salt of the covenant of thy God to be lacking from thy meal-offering; with all thine offerings thou shalt offer salt" (Lev. 2:13). Here, thru Moses, God tells the people of Israel, to be faithful in the sacrificial offerings at the altar. The custom of using salt in sacrifices in ancient times has led to a similar custom which the Jews still observe. Salt must

never fail to be present on the table, which at meal time is likened unto an altar.

A covenant of salt was a covenant of permanent continuance and perpetual obligation. This bond or rite was practiced largely among the Semitic peoples. Covenants were always made over a sacrificial meal in which salt was a necessary element. In Numbers 18:19 the Lord speaks of his covenant with Aaron and his sons, "All the heave-offerings of the holy things, which the children of Israel offer unto the Lord, have I given thee, and thy sons and thy daughters with thee, as a due forever: it is an everlasting covenant of salt before the Lord unto thee and to thy seed with thee." Again, we have the Lord's covenant with David and his seed, Abijah the king of Judah speaks to Jeroboam, the rival king of Israel: "O Jeroboam and all Israel; ought ye not to know that the Lord the God of Israel, gave the kingdom over Israel to David forever, even to him and to his sons by a covenant of salt?" (11 Chron. 13:5). It was the preservative qualities of salt that probably led to its being regarded as an essential element in the making of an everlasting covenant (Lev. 2:13; Nu. 18:19; 2 Chron. 13:5).

Though the word "covenant" is mentioned some two hundred fifty times in the Old Testament, it is surprising to find that the term "covenant of salt" appears only three times and then in exceptional connections.

Orthodox Jews still practice the rite of the covenant of salt. It is observed at their family table at each meal. After the words, "Blessed be thou O Lord our God, King of the universe, who causest bread to grow out of the earth," the head of the house breaks bread, dips it in salt and gives a portion to each one present.

The Bible also tells us the punishment for violating a covenant, "that soul shall be put off from his people he hath broken my covenant" (Gen. 17:14). And to those that keep his covenant, "the mercy of the Lord is from everlasting to everlasting," "To such as keep his covenant

and remember his commandments" (Psalm 103:17-18).

Salt was usually controlled by the rules, or sovereign of a government, in various countries thru the different ages. It was considered a source of life, or a great necessity for his people. If a subject received salt from the king's palace he was bound by a sacred obligation of fidelity to the king. In the Bible passage with reference to the rebuilding of the Temple at Jerusalem, the adversaries of Judah and Benjamin protested against receiving salt from a foreign ruler, "Now because we eat the salt of the palace and it is not meet for us to see the king's dishonor, therefore have we sent and certified the king" (Ezra 4:14). Further on in the same book we learn that King Darius gave the Jews salt, wine and oil in return for their services. The king, being a wise man, did not tell the Jews the amount of salt he had given them, knowing their belief that the more salt they received made them more firmly bound to him.

In our Bible, salt is also spoken of as destructive of vegetable and animal life. Ezekiel one of the priests and prophets of the Old Testament, foretold of a curse on the land of the Jews, "the marshes thereof, shall not be healed; they shall be given to salt" (Ezek. 47:11). When Abimelech captured Shechem, "he beat down the city and sowed it with salt" (Judg. 9:45); here we learn that when a captured city was doomed to utter destruction the final step was to sow it with salt.

Salt was not only used in sacrifices, destruction, foretelling events, but in performing miracles. It was the outward sign of Elisha's second miracle. The men of Jericho told him, "the water is naught, and the ground barren." Elisha said, "bring me a new cruse and put salt therein." And he went forth unto the spring of the waters, and cast the salt in there." "So the waters were healed unto this day according to the saying of Elisha which he spoke" (II King 2:19-22). The prophet Jeremiah foretold the consequences of one who departs from God's service he, "shall inhabit the parched places in

the wilderness, a salt land and not inhabited" (Jer. 17:6). The prophet Zephaniah declared that Moab would become, "a possession of nettles, and salt-pits, and a perpetual desolation."

There is five times as much salt in the Dead Sea as there is in the ocean. Fish and vegetable life are unable to exist in it, and yet it is a source of life to man in its endless supply of salt for his use. There are many old legends about the oceans. They are made up of the tears of all those who have suffered since the world began; and as tears are salt, the oceans waters are also salt. The Scandinavian legend tells us about a skipper who became tired of making long ocean voyages to obtain salt. So he bought a magic mill to grind salt for him. In the excitement about his purchase, he did not learn how to stop the mill from grinding. Eventually, it fell into the ocean; and there it lies at the bottom of the sea grinding salt day by day.

The story of Lot's wife has been connected with the fantastically shaped masses of rock covered with salt found southwest of the Dead Sea. Native guides in Palestine will point out a pile and tell you that it is Lot's wife who became salt. Legend tells us that she sinned through salt. The evening the two angels came to Sodom, Lot's wife went to her neighbors to borrow salt, for her guests. The real purpose was to make the men of Sodom acquainted with the guests. Therefore she became a pillar of salt (Gen. 19:26).

Salt is both a preserver and a destroyer. It is a very important element of the liquids in our bodies. We know that there is a presence of salt in our blood, tears and perspiration. In Oriental and primitive thought, salt and blood were in some sense synonymous in their uses. These people also believed that salt and blood had the same common properties. In parts of China and among peoples who had difficulty in obtaining salt, the fresh blood of animals and fowl was preserved and used as a substitute for salt.

Salt also preserves from corruption and renders food palatable, therefore it is used figuratively to represent the true disciples of Jesus, who by

their precepts and example raised the moral tone of society (Luke 14:34; Mark 9:50; Matt. 5:13). According to Saint Paul in Col. 4:6, salt also stood for wholesome character and speech. Thus he counseled the Colossian Christians, "Let your speech be alway with grace, seasoned with salt, that ye may know how ye ought to answer every man." For the most part it is used metaphorically in the Gospels, "Ye are the salt of the earth" (Matt. 5:13).

I am certain another reason here for the reference to salt is that salt is never indifferent, i.e., it can always be identified, even in traces—a little in a glass of water or in an ocean can be readily detected. How one can use this virtue today!

The spiritual life of the disciples was to cleanse and preserve the life of the world. Jesus warns the disciples of the danger of losing the power which would enable them to fulfill this duty, "for if the salt have lost his savour wherewith shall it be salted?" (Mark 9:50) (Matt. 5:13).

Salt was also used as a symbol of desirable qualities, a man with lively wit was a "man of salt." The Arab says of an especially lively and witty guest, "He was the salt of the party."

Wisdom was also typified by salt. Jews in biblical times rubbed a new-born child with salt. In later years if he should appear to be lacking in wisdom, it was said of him, "he was not salted." This also seems to be the prophet Ezekiel's thought when he reproached Jerusalem: "Neither wast thou washed in water to supple thee; thou wast not salted at all, nor swaddled 'at all'" (Ezek. 16:4). Today in the Roman Church salt exorcised and blessed is put on the tongue of the candidate at baptism as a symbol of wisdom and incorruption. Salt is also an essential element in all the holy water used in the Roman Church. It is still used in the Eucharistic Bread of the Greek Church. Salt represents life, and a sacrifice without salt is considered a dead sacrifice.

The early catechumen received salt in their mouths before they were allowed to receive the

Eucharist. Saint Augustine said in his *Treatise on Forgiveness of Sin and Baptism*, "What they received (salt) is holy although it is not the body of Christ"—referring to his receiving it himself he said, "I was now signed with the sign of the cross and was seasoned with His salt."

The most ancient highway in Italy, Via Salaria, was mainly a salt road and probably the route by which the Sabines came to fetch salt from the marshes at the mouth of the Tiber. The first Part of the road must be of very early origin, although today there is still considerable remains of its course thru the Apennines.

The widespread superstition that the spilling of salt produces evil consequences is supposed to have originated in the tradition that Judas Iscariot overturned a salt cellar at the Paschal Supper. Some copies of Leonardo da Vinci's painting, the Last Supper, have an overturned salt cellar beside the plate of Judas, showing that he had incurred the wrath of heaven. Today if an older person spills salt he will cast a bit over his left shoulder to "avert the omen."

The ancient Hebrews were not the only people who used salt in their religious services. The Chinese Buddhists added salt and wine when their sacrifices were essentially vegetable. Herodotus tells us in his "Account of Egypt," about the festival called, "the lighting of lamps." "The Egyptians gathered in the city of Sais for their sacrifices, and on a certain night they all kindled lamps in the open air round about the houses, the lamps were saucers full of salt and oil mixed." "Those who did not come to Sais to observe the festival, burned lamps at home." "Thus not in Sais alone but all over Egypt the lamps were lighted." The Egyptians also used salt for both the living and the dead; to render food palatable for the former and to embalm the latter.

At one time salt was regarded as being almost as valuable as gold. The soldiers, officials, and working people in Rome and Greece received at least part of their pay in salt. We derive our

word salary from the Latin "salarium," the money given to the Roman Soldiers for salt which was a part of their pay, from "salarium" belonging to salt, from "sal" salt. From this custom of paying with salt comes the popular expression, "not worth his salt," literally meaning "not worth his salary." . . . Centuries ago the "Great Salt" referred to the high or head table in English houses. The more important guests sat above "the salt" with the host and his family. Those seated "below the salt" or at the lower tables were the guests of lesser guests.

Aside from the ritual use of salt by religious cults, we know it is important medically. The ancient Hebrews rubbed their new born infants with salt (Ezek. 16:4), although we do not know of any medical benefit to the infant, as the result of such practice. However, we now realize that nature protects the infant's skin very well, so that bathing an infant during the first week of its life is discouraged, as soap and water remove the natural protection of oil from its body. Salt, or sodium chloride, occupies a unique position among the inorganic constituents of our food. Sodium chloride is the only salt we add to our diet, and although it exists in fairly large amounts in our food, we purposely add more. The other inorganic substances that are so important to our very life, we take unconsciously in our daily diet. It is estimated that the average man ingests between 10 and 20 grams of salt daily. This amount is in excess of our body requirement, for we have learned from experimental data, that one can remain in good condition when the total content of sodium chloride is reduced to 1 or 2 grams daily. For the most part the desire for salt is limited to people and ani-

mals whose diet is essentially vegetable. Accounts of travelers repeatedly tell us, that where a purely animal diet is used, there is no desire for salt, but where a vegetable diet is used there is a natural craving. It has been suggested also that this may be related to the fact that vegetables contain a large amount of potassium salts, and in the blood these react with the sodium chloride—at least it's a theory. There is also another theory that vegetable food contains but little salt in soluble form as compared to animal food. It cannot be doubted that we use too much salt in our diet, and used in excess it causes a dropsical condition of our tissues. Conditions such as dropsy from heart and kidney disease, can be greatly helped by the reduction of salt intake. Even withholding milk from these patients, since milk does contain salt, will help considerably. The ancient Arab realized that milk contained a high percentage of salt, for at various times it has been recorded that they used milk in the place of salt in making a covenant. We also know that the use of a normal salt solution of 0.9% sodium chloride imitates the normal amount of salt in our blood.

From ancient times up to the present day salt has always been a valuable commodity. Wars have been fought over it, men have been murdered for it. Primitive and Oriental man thought it was a gift of the Gods, to these people salt and blood were in some sense synonymous in their uses. Salt was blood, and blood to them represented life. Today that product which has meant so much to man from time immemorial, is accepted and used as freely as the water which we drink.

PLAN NOW TO ATTEND THE SEMIANNUAL MEETING

Friday, September 12, 1952—Headquarters, Commander Hotel,
Ocean City, Maryland

SYMPOSIUM ON THE DOCTOR IN COURT

Continued from the April issue

DR. WISE: With our next speaker, we go into the field of Psychiatry, and certainly we have a speaker who should speak with authority.

Dr. Guttmacher is a graduate of the Johns Hopkins Medical School. He has been Chief Medical Officer for the Supreme Bench since 1930. He was formerly psychiatric advisor to the Committee of the United Nations, studying causes and treatment of crime.

He was a Gimbel Lecturer, in Stanford University, in 1950. He has been Chairman of the Legal Aspect Committee of the American Psychiatric Association since 1948.

He is a member, and former Chairman, of the Forensic

Committee, and Group for the Advancement of Psychiatry, since 1947 to the present.

He was Chief Psychiatric Consultant to the Second Army, and had an important position in World War II, in the Third Service Command, and in the Surgeon General's Office. He is a member of the Joint Committee of the American Bar Association and American Psychiatric Association, on the relation of psychiatry to law.

With this wonderful background, he should and will speak with authority on his subject, which is that of Expert Testimony from the point of view of the Psychiatrist.

EXPERT TESTIMONY FROM THE VIEWPOINT OF PSYCHIATRY

MANFRED S. GUTTMACHER, M.D.⁶

Some of the most important of the legal philosophers stress the fact that a trial is not a scientific investigation. It is not a search for objective truth. The function of a court is social and political, not scientific. Its chief contribution is to the security of the individual and to that of the community. It resolves individual and community tensions.

The pursuit of truth may take decades. And justice delayed is often justice denied.

I think it worthwhile to pause for a moment and consider in a very superficial way the history of trial procedure. Admittedly I do this with gross and inadequate strokes.

An early method was trial by battle, of which the duel is a survival. Then, there was trial by ordeal, which had in itself an important medical element. Individuals had to undergo certain ordeals, such as walking across molten plowshares, or carrying a white hot iron a certain number of feet. Then the hand was bound up, or the feet were bound, and in a certain number of days

these wounds were inspected. If the wounds were healing satisfactorily, the accused was considered to be not guilty. If the wounds were infected and healing badly, he was considered guilty. God was not on his side. And consequently he was punished, and often executed.

This was frequently the method by which witches were tried. A pool of water was blessed, and the witches were thrown in. If their garments were voluminous enough to keep them up so they floated, they were considered guilty, because the water had rejected them. If they sank, they were allowed to go down a couple of times, and then pulled out as innocent.

These were the very early methods of trial. They were followed by trial by compurgation. That was a method of trial where a group of your neighbors would come in and swear that you were incapable of doing the act of which you were charged. If, despite the oaths of these people, it was found that you had committed the act, they suffered the same penalty that you did. So it was not easy to get people to come in and testify. However, this was a common method of trial.

⁶ Medical Officer, Supreme Bench of Baltimore.

The jury method of trial has gradually evolved. Originally the jury was composed of people who were familiar with the facts of the case. People living in a small area were called together, and they decided the case, largely on the basis of their own knowledge of the situation.

Today, of course, an individual is disqualified if he has any personal knowledge of the situation of which he is the judge.

These are not scientific methods, nor is our present method of trial scientific. It does the best that it can under the situation that exists. I think, however, that anyone who observes the trial process with an objective eye could not consider it a scientific process.

This is an important thing for doctors to realize when they become disturbed and show great disquietude about the law and its vagaries. I think they have got to realize that the function of the law is to resolve individual and community tension, and not to arrive at scientific truth. Lawyers must realize, and I think few of them do, how alien the spirit of the ordinary trial is to the average doctor. He is accustomed to being listened to deferentially by his colleagues and by his patients when his opinion is sought. He is by nature independent—under our American system—he has no boss—he pursues his vocation and his investigations by his own methods. In the courtroom everything is changed. He is not permitted to express his findings nor his opinions in his own way. He is told when to speak and when to keep quiet. He is badgered by lawyers, who often try to provoke him to anger. Not only is the accuracy of his view questioned, but his motives and integrity are assailed.

So that there is little wonder that most doctors are at least loath to come into a courtroom.

As the Chairman of the Legal Aspects Committee of the American Psychiatric Association, I recently sent out a questionnaire, to find out what the attitudes of psychiatrists were toward this whole problem. I found that about twenty per cent of the psychiatrists were unwilling to go into court in a criminal case, and another

fifteen per cent were unwilling to serve as experts in criminal cases except where they were employed by the court. Eighty per cent of the psychiatrists found that the commonly accepted legal tests of responsibility were unsatisfactory. Less than half of them felt that they could accurately present their findings and opinions under the present methods of court procedure. The greatest number based this on the partisan role that they had to play in the trial process. The next largest number felt that the restrictions inherent in the inquisitorial method as contrasted to the expository method was the greatest handicap—they had to answer the questions which were given them by answering yes or no, rather than to freely express their knowledge and opinions.

I do not think that anyone who has worked in the courts can feel that we are going to give the maximum degree of medical help to the courts—and that is what they want—by the time honored system partisan testimony.

One of the first cases in which I was ever privately employed was before the State Industrial Accident Commission. It was shortly after I came back to Baltimore to practice. A man was unloading a beer truck and had inexpertly allowed a full barrel to roll down on his head, with rather disastrous results. I had examined him, for one side or the other, I cannot remember which. I was sitting there, biding my time, as we so often do in the court process.

I saw Dr. Charles Bagley in the room, and I went over and asked why he was there. He mentioned the same case that I was in. We then discussed it. I said to him after a few minutes, somewhat facetiously, "Since we are in such complete agreement we ought to toss a coin and see which one has to testify." And he said, "I am afraid you are young, and still a little naive; by the time your lawyer gets you to stretch the truth as far as it can be stretched, and my lawyer gets through stretching the truth as far as he can, nobody will feel that we were in the slightest agreement."

I thought those were bitter words and that he was a cynical fellow. Or perhaps he was feeling a bit dyspeptic. But actually since then, I have learned they were very wise words, and that they were realistic words. I think if one is going to be realistic, one has to accept this truth, and one has to view the trial as a kind of sporting contest. It has aspects to it that are dramatic, and it challenges intellectual agility. It produces some great thinkers and some great men. Many of the great leaders of our country have been trained by this process. However, I don't think we should delude ourselves into thinking that this is the way that medical truth can be brought to the courts.

I understand that it is generally held that there is a common law right for the courts to appoint experts to advise them. However, there are two States, Michigan and Illinois, where the appellate courts have decided that that is not permitted. The late Professor Wigmore, of Northwestern University, one of the great authorities on the Law of Evidence, stated that this was bad law, and that the courts have this inherent right. In most jurisdictions, particularly in criminal cases, this is the current practice.

We have the well-known Briggs law in Massachusetts, named after Dr. Vernon Briggs. It was passed in 1921. This law provides that qualified neutral examiners, selected by the Commissioner of Mental Health, examine all individuals charged with a major crime, prior to trial. A report is filed with the court, which goes to both the prosecution and the defense.

In Colorado the individual is sent to the State Hospital as soon as the "not guilty because of insanity" plea is made. He remains there for thirty days, and the State Hospital renders a report to the court.

There are six metropolitan centers, of which Baltimore, I am happy to say, is one, where in a large number of the more important criminal cases, and those in which psychopathology is most likely to exist, individuals are examined by neutral psychiatrists, and a report made to the

court. Here this report is also available to the defense and the prosecution.

The Model Code of Evidence of the American Law Institute, and the Federal Rules of Criminal Procedure, converge towards this one point of bringing into the trial process the nonpartisan expert.

The Model Code of Evidence of the American Law Institute works it out in this way: The parties agree on the experts who serve. If they cannot reach an agreement, then the matter is taken before the Court, and the Court picks the experts. These experts all have the right to examine the individual personally. They meet together, and frame a joint report if possible. If not, and if there are more than two experts, there is a majority report and a minority report. The report is then filed with the court, and it is available to both parties.

Of course, these various systems do not deprive either side of the right to introduce their own experts, if they wish to controvert the evidence of this neutral examiner. However, this is done rarely. It is seldom done in Baltimore in criminal cases, not because Dr. Boslow and I are such wise psychiatrists, but because the judge and the juries realize, as one juror put it to me early in my career, that we have no axe to grind.

Juries are confused by medical testimony anyway, and they would rather go along with the contention of the neutral expert than with the contention of the partisan expert.

Experience shows that wherever you have these groups of nonpartisan experts, it is going to be hardly worthwhile to oppose them, even though the legal right to do so exists.

In Continental Courts, they do not have partisan experts. Recently I read a report of a psychiatrist at Yale who was making a study of Continental Court procedures. The men who do psychiatric testifying in the Continental Courts are held in the highest regard. They are leaders of their profession, and they are not subjected to the type of treatment that so often is meted out to the expert in our trial process.

Perhaps we ought to be tough and not mind such things. As a matter of fact, I have gotten tough, and I don't mind it very much, but for those of you who are not used to it, it is sometimes a pretty humiliating procedure.

An American Bar Association Committee has advocated, as Dr. Wolff did earlier this evening, that the remuneration of these court appointed experts should come out of court costs.

The next thing we would like to see, would be doing away with the hypothetical question.

Professor Wigmore says that the hypothetical question is one of the few truly scientific features of the rules of evidence. But in practice the logic breaks down, and he admits that the hypothetical question "misused by the clumsy, and abused by the clever, has in practice led to intolerable obstruction of the truth." Dr. William A. White called it a "monstrosity."

Much has been written about the hypothetical question, and it makes very interesting reading. I remember one article detailing a case where a man was to assume the truth of all the evidence, one witness having stated the defendant weighed one hundred pounds, another one had said one hundred and twenty pounds, while still a third gave the weight as one hundred and seventy-five. Remember, you have to assume all those things to be true in order to arrive at a just conclusion. And that is very difficult.

Both the Uniform Expert Testimony Act and the Model Code of Evidence of the American Law Institute advocate an expression by the expert of his opinion and then for him to tell on what it is based. Under such a system the expert would not be hampered by the presiding judge, nor bothered by the opposing counsel, but be allowed freely to express his opinion, and then to explain fully on what he had based his opinion. After that he could be cross-examined.

Today there are many judges—and I must say that many of the members of the Supreme Bench certainly are among them—who will permit an expert a great deal of freedom in expressing himself.

I was unfortunate enough to be in a trial in Virginia not so very long ago where no such freedom was permitted. The latitude varies greatly from one community to another. Those who have had little court experience have the misconception that law is a rigid discipline. Functionally, it is remarkably elastic. The hypothetical question need scarcely ever to be employed if the expert is permitted to give his opinion and to state fully the data on which this opinion is based.

Then there is a third point. I think there should be modernization of the legal definitions of certain mental conditions. Most of these definitions date back a century or more, a period when faculty psychology and the cult of phrenology were dominant. Intellect and reason were supposed to be discrete. They were in an airtight compartment, separate from emotion and will. This, of course, we know now to be nonsense.

These old legal rules, these old legal definitions, are not sacrosanct. I think there are many doctors, and many lawyers, and even some judges who feel that they are sacrosanct.

The law is subject to change, and the law is, theoretically, at least, supposed to keep pace with scientific progress. Only this last month, Justice Biggs, in an appeal to the Third Judicial Circuit of the United States Courts wrote an opinion which blasted the McNaughten rule with respect to criminal responsibility much more effectively than any psychiatrist I ever heard of blast these rules.

So that, it does not mean that these things are mummified and are to stay for all time. They are subject to change.

The McNaughten rule came down to us from a famous trial in 1843. And the burden of it is that if the individual knows right from wrong and realizes the nature and consequences of his act, he is a responsible agent.

There has been a great deal of debate on whether right or wrong is moral right or legal right. Justice Cardozo in the Schmidt case held that it was moral right. There are certain psy-

chiatrists who have refused to answer these questions. Dr. Philip Roche of Philadelphia, and Dr. Gregory Zilboorg of New York, say that these are for theologians, that they are problems in ethics, and hence should be answered by the clergy and not by psychiatrists.

Then, of course, there is also the question of delusion, that enters into the McNaughten rule. If a man acts on the basis of insane delusion, he is exculpated only if he had been justified in his actions, had the delusive belief been real.

For instance, a man turns around and stabs somebody, because he had the delusion that this man was after him and had a knife at his back. In this case he would not be considered a responsible agent.

Isaac Ray, the most prominent legal psychiatrist of his time, made a very illuminating comment on this seventy-five years ago. He said, "A lunatic will not be held responsible for his act provided only that he acts with reason and propriety."

Then there was a famous case, the Burton case, in 1863, in England. Burton was an eighteen year old schizophrenic who killed a lad because he wanted to be hanged, and he felt if he killed this perfectly innocent boy, that was one sure way to be hanged. Justice Wightman pointed out with fine legal reasoning that this clearly proved that Burton was responsible, since he clearly recognized that he would be punished, otherwise he would not have committed the act. When the death sentence was passed, Burton thanked the court very deferentially. Dr. Henry Maudsley, the leader of English psychiatry in that day, observed, "he was in due course executed; the terrible example having been thought necessary in order to deter others out of doing murder, out of a morbid design to indulge in the gratification of being hanged."

I think it is important for us physicians to realize that the law is not attempting to diagnose psychoses when it deals with the question of criminal responsibility. The law merely attempts

to pick out and to isolate certain offenders who are non-deterrable and whose execution will have little or no value in deterring other individuals. The crucial issue is whether the McNaughten rule really picks out these individuals. I feel that psychiatrists in general think it does not do so efficiently.

I think that the widest acceptance would probably be found among psychiatrists if a rule were framed with these points in mind: First, that the individual is a well recognized mental disorder; second, that it had manifested itself by significantly distorting the individual's social judgment, and/or three, had seriously interfered with the exercise of customary social control.

I feel that some attempt should be made to frame a definition that would satisfy psychiatrists rather than to continue to talk in terms of right and wrong, concepts which are extremely difficult to handle.

So far as the Maryland law is concerned, I should suggest the changes which I have discussed which I think are largely procedural reforms, particularly the use of nonpartisan experts. These should be applied not only in criminal trials, but in civil trials as far as possible. I think a panel of fully qualified experts should be nominated by the Medical Society, from which the lawyers and judges could choose, perhaps in rotation. In addition to this, efforts should be made to do away with the hypothetical question and to modernize legal concepts on insanity.

My time is growing short, and I merely want to make two more points.

I think one of the things that should be changed in the Maryland law is the fact that people who are found not guilty of a crime because of insanity and who have apparently recovered by the time of trial cannot be held. In other words, if a man committed a murder six months ago and at that time was insane, and he is subsequently caught and brought to trial, and in the meantime has apparently recovered, he is no longer able to be legally held in either a penal

or mental institution. He goes free in the community.

Maryland is one of the few states where such a situation exists. I think there are only eight. In most states the accused automatically is held after trial, when he has been found not guilty by reason of insanity. In one state he must remain in a mental hospital for one year, and in another state for two years. These statutes have been upheld by the appellate courts. I think that our Maryland system makes a travesty of the legal plea of insanity, when an individual can be relieved of the responsibility of crime because of mental disease, and a few months later can be considered entirely well and permitted to be at large.

It is the first duty of the law to give protection to citizens and to protect the community. And it seems to me that any one who has been sufficiently disturbed or disordered to have committed a crime and not be considered responsible for it, should be in a hospital for a prolonged period of observation, so that the community can be certain that there will not be a recurrence of this condition.

Now my last point. Maryland is one of the states that has no privileged communication status for physicians. This is a subject about which some of my colleagues get very much upset. I personally cannot become so upset about it. Of course, in the majority of states the physician has a privileged status. Recently some of the legal writers have been in favor of abolishing privileged communications altogether medically.

It has been brought into disrepute largely through personal injury cases. A man in a state that has such a statute will go to a doctor after

an accident for first aid and the doctor will find comparatively little injury. As the injured man sees more doctors and sees more lawyers, and talks to more friends, a case is made out. And naturally, his lawyers don't want the first doctor in court, because it is obvious that his testimony would not be particularly helpful. He is thereupon told that he does not have to come into Court, in fact his patient does not want him to come into Court, claiming that the contact with the physician was privileged.

I certainly know very little about the law, but I think it would be possible to have a law passed granting privileged status for physicians except in personal injury cases. I believe such a law could be written and passed.

DR. WISE: As I stated earlier, I am more and more convinced that we are really accomplishing something. We have heard various phases of this expert testimony subject discussed, and we will now have the judicial attitude about it. The next paper will be by W. Conwell Smith, Chief Judge of the Supreme Bench of Baltimore City. Judge Smith was admitted to the Bar in 1908. He began practice shortly thereafter, being associated with prominent firms here, and then went in World War I as a private, rapidly rising to become an officer, and served as airplane pilot with the Corps d'armee up to 1919, when he resumed his law practice in Baltimore, until elected to the Bench. He has been vice-president of the Bar Association of Baltimore City, and president of the Bar Association of Baltimore City. He was elected to be Associate Judge of the Supreme Bench of Baltimore City in 1938. He served there until September 1, 1944, when he resigned to accept the appointment of Chief Judge. He served until the general election of 1946, at which time he was elected to the Chief Judgeship of Baltimore City. To be Chief Judge of the Supreme Bench of Baltimore City, with the high standards of our Bench that I referred to earlier, is a real honor.

EXPERT TESTIMONY FROM THE VIEWPOINT OF THE JURIST

HONORABLE W. CONWELL SMITH⁷

Baltimore is both a great center of Medical learning and research, and likewise a City whose Doctors of Medicine are equal in knowledge and skill to those to be found anywhere in the world. It is, therefore, a real pleasure for me to have the opportunity to serve on a joint panel of doctors and men of my own profession—the law.

We have frequent occasion to employ the services of our Medical Officer, Dr. Manfred Guttmacher, in criminal cases; to give opinion as to mental responsibility of offenders in doubtful cases, and also to diagnose the mental and physical condition of offenders, and recommend treatment or disposition. We hopefully employ blood tests to exclude paternity in bastardy cases. Our procedural rules in civil cases provide for the opportunity to make mental or physical examinations of persons whose mental or physical condition is the subject of controversy, in advance of the trial—and for the production of medical evidence at the trial, unless there is by that time agreement on the condition. Without the scientific knowledge of medical men many obscure injuries and maladies would go unrecognized and uncompensated, while many other pretended sufferings would be undeservedly rewarded.

The standard of medical evidence given in the courts is not always high, and there is among lawyers some distrust of medical evidence, while there is on the part of reputable doctors a distrust of courts and juries, and a reluctance to appear as a witness. Why? This distrust of courts may well be illustrated by the practice in vogue in the hospitals until a year or two since, of sending to court the hospital record in the custody of a girl from the hospital library, whose presence was not necessary to identify it, and who remained in the court room until the record might be given back to her, and so returned to the hospital.

Hospital records are now summoned through the Police Department, are receipted for to the hospital by the Police, delivered to the Clerk of the Supreme Bench, receipted for by him, used in the court where required and thereafter returned through the same channels to the hospital. Meantime, the librarian remains in the hospital instead of wasting her time sitting around the court room. And the ease with which the production of these records may be obtained dispenses with the necessity of requiring the attendance and testimony of members of the hospital staff in many cases.

Before I mention the reasons which make reputable doctors shun the courts, let me suggest that lawyers have not too high regard for opinion evidence—summed up in the statement that there are “liars, damn liars, and experts.” The reasons which underlie this distrust are:

First—The lack of any certain standard for the witness to measure up to—the standard may be met by any quack, and any quack may testify.

Second—The fee paid often influences the opinion expressed—that is to say, bias is clearly apparent.

Third—The production of opinion evidence results in the needless prolongation of trials, without producing a more satisfactory result.

Fourth—The opinions expressed are frequently so contrary to common sense and common experience as to provoke the suspicion that they are dishonest.

Fifth—Expert testimony is a purchasable quantity—available to the highest bidder.

Now the doctors, on their part, have reason to feel some dissatisfaction with their infrequent court appearances. On the day and hour on which they have planned to testify, the case has been postponed, for some reason—and is finally reached on an awkward day, at an awkward time. Then he is treated with scant respect by

⁷ Chief Judge, Supreme Bench of Baltimore City.

the cross examiner, only to find that on some points it is difficult to demonstrate the falsity of conflicting claims. Sometimes the jury's verdict is unsatisfactory—at best it is uncertain. Sometimes his evidence is not accepted, not fully believed, although well informed, and thoroughly honest, and this is distasteful. Particularly when the evidence in opposition is merely crafty and dishonest.

Both doctors and lawyers are in agreement that it is deplorable to have dishonest testimony succeed, and go unrebuked and unpunished. But they are not in agreement as to the solution. They approach it from different view points.

The doctors say the solution lies in excluding the quacks from the witness stand. Let the Court call in a reputable trustworthy expert, tax the cost equally against the parties—and let his answer furnish the solution to the controversy. You will attain a more satisfactory, a more desirable result. I served some fifteen years ago on a Bar Association Committee in conjunction with a committee of the Medical Faculty. The Committee of Doctors furnished a panel of experts in all branches of medicine, subject to call, willing to give their services at the call of the court to promote the ends of justice. But they had few if any calls; while the quacks continued their practice and their practices.

The difficulty with this solution is that under existing conceptions of fair hearing and trial, the production of any competent evidence on either side, including opinion evidence, cannot be prevented altogether. In rare cases, the court may call in an impartial expert, but only by consent, and consent also must be had to abandon the right to call evidence in opposition.

A court trial is not a mere inquiry to determine the truth or falsity of conflicting claims. It is an adversary proceeding in which the written, and sometimes sworn statements and counter-statements of the parties are climaxed by a hearing before the Court and jury—where the parties, and the witnesses, and counsel appear in person to be heard by both evidence and argument and

the case decided. The fairness of the hearing forbids that any evidence be excluded, except for good reason, even opinion evidence, where there is proven qualification to express opinion. So the undesirable testimony can not be rejected. It must be overcome by other proof.

While medical men are eager to make use of the new drugs and the latest techniques, the men of law are slow to adopt new things. They tend to follow old precedents. This is particularly true of the courts. But while following the old procedures it is still possible to improve the result. One most important method is by selection, to improve the quality of the jury. A more intelligent jury is much more apt to accept well informed and honest medical opinion and to reject false claims. We have been able to enlarge and improve our jury lists in the last several years; the qualification of women for jury duty in itself has doubled the number of eligible persons.

Mental or physical examinations in advance of the trial, where the parties avail themselves of this privilege, prevent surprise at the hearing. The power of the Court to regulate and control these inquiries will usually prevent surprise—the opinions to be expressed by expert witnesses before the jury are often known in advance, so that they may be controverted. This has a strong tendency to repress the expression of palpably false opinion evidence and to prevent its acceptance by the jury.

Lastly, the Judge who presides at the trial has great power. I should perhaps express it this way,—he has a great reservoir of power, which he may legitimately and properly exercise to control counsel, the parties and their witnesses. This power is not always exercised—not called upon—because in most cases, there is no occasion for its exercise. The judge must not only be impartial, but appear to be impartial—he must not take sides. But he may inject his influence into the trial when needed—on the side of truth and justice. And should any miscarriage of justice

occur, he has the uncontrolled power to set aside the verdict, and grant a new trial.

A combination—or perhaps a compromise—of the medical and legal means for overcoming improper medical expert testimony is the Minnesota plan. That plan contemplates that judges, lawyers and doctors will be asked to call to the attention of appropriate committees of the medical and bar associations any conscious deviations from the truth that they may observe in the testimony of expert witnesses, and that the transcript of testimony will be submitted to an impartial group of doctors. The effort here is to hold the offender up to shame and ridicule in his own profession. It has had a fair degree of success in preventing a repetition of the offense. But it has the fault of failing to catch the culprit until his conduct becomes notorious.

My own opinion leans to the fuller exercise of the means that are now available to hold the offender up to scorn then and there, when the offense occurs—to prevention, rather than cure.

When I sat in the Common Pleas a few years ago, I heard two or three suits against the transit company, with the same lawyer for the plaintiff, same type of accident, and the same doctor, treating the same complaint. In each case, the plaintiff, while alighting from a car, was thrown off by a premature start and suffered a back injury. The doctor found a sacro-iliac injury and prescribed heat treatments. All the accidents were unreported. The cases tried before me resulted in verdicts for the defendant. I was told by the attorney for the transit company that the same lawyer had filed twenty-six such cases, all of which followed the same pattern, and all tried to that date resulted in verdicts for the company.

The doctor testified in each case as to the back injury, the prescribed heat treatments, and eventual recovery. But after cross examination, nobody believed him.

A great many years ago I was defending cases for the Yellow Cab Company. I appeared in a case before Judge Henry Duffy in which both the cab company and the United Railways were

being sued. A street corner collision between a taxicab and a street car had knocked the car off the track and caused it to run down the street into a parked automobile in which the plaintiff sat. He was only slightly injured but could not resist the temptation to make his injury appear more serious. He produced a doctor who testified that his patient had a gash in his head an inch and a half deep—"Without reaching the skull?" asked Judge Duffy, and turned his head aside in distaste.

It happened to be the last day of service for that particular jury, so when I addressed them I said something like this: "Gentlemen, in the course of your service here, I dare say you have had occasion to hear a good many injury cases, and have heard some exaggerated claims of injury. Now, if you disapprove that kind of thing and want to put a stop to it, bring in a verdict here in favor of the defendants." That appeal to the jury won unanimous approval in very short order—and the jury's expression of approval was somewhat vehement, even boisterous—but Judge Duffy made no effort to subdue it.

The power of the court to set aside a verdict because of the amount of damages is much more frequently exercised on high verdicts rather than low ones. New trials are seldom granted because of inadequate damages. And verdicts in small cases are more apt to stand than verdicts in big cases. On the average I would say that plaintiffs in injury cases receive less than they ought to get. Cases in which the verdict is lower than the settlement offered are not at all uncommon.

There are still, and probably always will be areas in which there is room for wide but honest difference of opinion. And in nervous and mental disease these areas are broader than in the medical field. (The story of the two psychiatrists has taken the place of the story about the two Irishmen.) In these areas simulated injury or suffering are difficult to detect; but on the other hand they are likewise difficult to demonstrate convincingly when they do in fact exist.

Flagrant abuses in medical evidence have been

rare, in my experience—and more apt to occur in small rather than large cases. I believe we are fortunate, in that jury verdicts have been conservative rather than extravagant in the assessment of damages. We are also fortunate to have available, at need, abundant medical knowledge

and skill to call upon. Any plan for the elevation of the standard of medical evidence in the trial of cases, which may be accomplished within the rules of evidence, will have the sympathetic consideration of the courts.

QUESTION AND ANSWER PERIOD

DR. WISE: I hope you don't think that the presentation of the five papers ends the meeting. The question and answer period is now coming up. We ought to develop some very interesting discussion in this period.

While the panel is arranging itself by the microphones, I am going to ask if Mr. Waters and Mr. Serio will constitute themselves ushers, or whatever we may call them, to pick up any written questions. There are little pads of note paper on your program, and a pencil in your neighborhood, no doubt. There is no objection to rising and addressing your question to the member of the panel of your choice. But the written questions are more easily handled, as there are no microphones in the audience and we can state them more clearly perhaps if you write them.

If anyone has any questions, hold them up, and the usher will bring them to the chairman.

I have some questions already presented and I am going to start in the order of rank, asking Judge Smith to answer the first one.

Q. In your opinion, would it be advisable for the Rules of Evidence to be amended to permit the court to call independent medical experts to testify on behalf of the court in cases involving controverted medical issues?

That has been spoken of a good deal, and you spoke of it also, and you might like to answer that.

JUDGE SMITH: My answer is yes, but it should be a state-wide law. I think the Attorney General has ruled that any law on the subject of costs

must be state-wide, and it should be left to the discretion of the court, but not be compulsory and merely at the request of one party.

Q. DR. WISE: I have a question for Dr. Eaton. Is it a good thing to be known as a doctor who frequently testifies in court?

DR. EATON: Generally speaking, I believe it is not a good thing to be known as a doctor who is always in court. On the other hand, it is a perfectly legitimate way to become known in the community, and if the doctor conducts himself according to our standard of ethics, he is rendering a distinct service to the community in doing this type of work.

Q. DR. WISE: I have a question for Dr. Wolff. Would counsel for either side under this proposed plan be able to contact the expert medical witness while reviewing the evidence before him?

DR. WOLFF: Medical evidence reviewed by expert witnesses may take place under a great variety of conditions. It does seem to me in the process of their investigations they may be required to do special examinations. They may be required to spend considerable time in their own studies, working up the conclusions to which they are about to arrive. And in the process of studying and arriving at these conclusions, it should be most important that no interested person be able to contact these expert witnesses; that lawyers for either one side or the other should be interdicted from so doing either by telephone or through any other means, and that any attempt whatever to influence the opinions of such experts while they are attempting to make up their

minds about the subject at issue would be regarded as the same sort of offense as tampering with the jury.

Q. DR. WISE: I have a question which is directed to Dr. Guttmacher. What do you think should be the test of criminal insanity?

DR. GUTTMACHER: I cannot presume to phrase the test in legal language. I think that every person to be irresponsible criminally should be suffering from a well recognized mental disease, and that it should be shown that this disease has affected his judgment and his social behavior, as well as his self control.

Now, the New Hampshire test, which has been in existence since 1869, is in large measure that test. New Hampshire is the only place that has such a test. There are thirty states that have the knowledge of right and wrong concept as the sole test, and there are seventeen additional states which have the irresistible impulse. I think it is a simpler thing to define responsibility somewhat on the order of the New Hampshire rule. I think it would be safe to conclude that the offender meeting this test would not be a deterrable individual and that his punishment would not act as a particularly salutary influence on him or on the community in general.

Q. DR. WISE: Now, I have a question from the floor. (Addressing the panel) If you get nearer to the microphones, the people in the back seats can hear you. There is no objection to your remaining seated if you so desire, and you will not be considered impolite. The question is for Mr. Coughlan. Is it or is it not possible from a practical standpoint for the doctors to formulate a method by which the percentage of disability can be computed?

MR. COUGHLAN: I would think that such a method could be developed. I make that statement for the reason that in eye cases there are charts, and in many ear cases charts to determine the question of deafness. There are methods for doing that. It would seem to me that the doctors who are familiar with industrial accidents could

arrive at some basis so that there would not be such a wide divergence of view.

Q. DR. WISE: I have another question for Judge Smith. In proceedings before the Industrial Accident Commission, do you believe it would improve the administration of the law to provide a medical board of medical examiners to testify on behalf of the Commission in cases involving controverted medical issues in cases of traumatic injury?

JUDGE SMITH: Yes, I understood Dr. Wolff to say that there is such a board.

Q. DR. WISE: That is for industrial diseases, the Industrial Accident Commission has a doctor who acts as a sort of referee?

JUDGE SMITH: Yes. The Accident Commission has always had a physician. At least, it did in my days, but it has been a long time since I have been in contact with the Accident Commission.

DR. WOLFF: May I take that over?

JUDGE SMITH: I would be glad if you would.

DR. WOLFF: Judge Smith, the way the situation is at present in our relationship with the State Industrial Accident Commission, of which our Board is an advisory branch, if the State Industrial Accident Commission finds the medical expert on the subject at issue, it requests a hearing on the part of the Medical Board for Occupational Diseases. We then order such a hearing, express our opinion, and report to the Commission accordingly.

Q. JUDGE SMITH: Well, does the Commission have its own physician?

DR. WOLFF: Yes, it has, although it has no physician now.

DR. WISE: Yes, it is vacant right now, but temporarily filled.

DR. WOLFF: We once had Dr. Robert Bay. He has been dead for some years. But we still have a physician.

Q. JUDGE SMITH: Don't they call on him to inquire into and testify in cases where there is a dispute?

DR. WOLFF: I cannot answer that question of

my own knowledge. I assume that they do. But I know this much, as I said before, that when there is a distinct occupational disease angle to it, the matter is turned over to the Medical Board for Occupational Diseases, and we express our opinion on the testimony. That is the way it is done.

MR. COUGHLAN: Dr. Wise, in answer to Judge Smith's question, the Commission does have a doctor to whom such cases are referred. The Commission's doctor makes the examination and files a report with the Commission, but this report may not be used in evidence should there be an appeal. The practice is for the Commission to send a copy of the doctor's report, who makes the examination on their behalf, to each side and to notify each side that this report will be considered unless objection is made to it within a certain period of time. On appeal, either side may summons the doctor who made this examination for the purpose of having him testify, but the report is not admissible in evidence on appeal.

DR. WISE: We are glad to have it clarified, Mr. Coughlan. There is a question that is not designated to anyone on the panel. I would like to refer it to Dr. Guttmacher, or I could answer it myself.

Q. The Bar Association has an appropriate committee to police the actions of its members. Does the Medical Association have a similar setup?

DR. WISE: Well, the State Society does have the machinery, but I must say, and I regret to say it, that it has never been enforced as much as it should have been.

There is also, in addition to the machinery of the Society, the State Board of Medical Examiners, which has control of the actions of its members.

There is a serious effort being made now, through several channels, to discipline our members a little more than has been done and I hope a good deal more than has been done.

DR. WISE: I have a question for Dr. Wolff.

Q. Would not your so-called medical experts appointed by the court replace judge and jury? Who would decide who is a medical expert? That is question B. It is divided into two parts. The first part I read was A, and the second part was B.

DR. WOLFF: The medical expert would not replace the judge and jury. The medical experts would reach conclusions after proper study and investigation of the facts, and announce its conclusion to the properly constituted authorities. The expert would then be under the necessity of being cross-questioned by opposing counsel, at the end of which time, if it were a jury trial, the jury would then take the case and make the ultimate decision, using the best information that it had. It would operate in that manner.

The second question was, Who would decide who is the medical expert. It would appear to me that something along this line might be worked out, that the Medical Society, the Baltimore City Medical, and the Medical and Chirurgical Faculty of Maryland could appoint a group of men to make a study of this particular problem. This group could then issue the names of those who were known to be properly qualified as experts, citing the particular line in which each person was known to be an expert. That would constitute a Panel of Experts. And that panel would be changed sufficiently often so that service on the panel would not become an undue burden to the individuals placed on this panel.

Q. What do you mean, the lawyer should guarantee the fee?

DR. EATON: I meant just what I said.

Some of us have found it very suitable, when we are contacted by a lawyer to examine his client and render an opinion and be ready to testify in court, to say, who is going to pay for it? When he does not know what we mean, and he says, "I am on a contingent basis, I may not win this case," we say, "We are not interested in being included on a contingent basis." And the inference is if that lawyer thinks he has a good

enough case, he will gamble the expenses of the doctor's fee in the matter.

Q. MR. WILLIAM D. MACMILLAN: Do you suggest that the doctors should share in the contingent fee?

DR. EATON: He should not.

Q. MR. MACMILLAN: Do you think the doctors should indulge in that practice?

DR. EATON: I have no opinion on that.

DR. GUTTMACHER: I think there was a case in court in which the doctor was frowned upon acting in a case on a contingent basis.

Q. MR. SAMUEL H. FELDSTEIN: May I ask, is it unethical for the doctor to advance costs on behalf of a client?

DR. EATON: Why should it be?

MR. FELDSTEIN: Well it is. Judge Smith will tell you that.

JUDGE SMITH: Well, it is from the lawyer's standpoint, but from the doctor's standpoint, I can understand it.

DR. WISE: This question is not designated.

Q. Could it be possible to settle the medical aspects of the legal question in the doctor's office with two doctors and two lawyers present?

I think Judge Smith should answer that.

JUDGE SMITH: There are many cases in which the parties may agree to submit the troublesome medical questions to an impartial doctor. That has not been altogether infrequent. And where there is agreement, the court selects the doctor, and he is allowed to testify in the case. Of course, under our rules, if they don't agree, if that doctor decided against them, they want to call another doctor to contradict him. You could expect two doctors to agree. But if you bring in two lawyers, you know there would be no agreement.

Q. DR. WISE: Dr. Guttmacher, here is a question. How adequate, from a psychiatric point of view, are the rules governing responsibility laid down in the Spencer case?

DR. GUTTMACHER: I think we have pretty well answered that. The Spencer case was in 1888, and it follows the McNaughten case very closely.

Spencer finally committed suicide. Although he had been found responsible by the court, I think it is perfectly clear that poor Spencer was pretty sick; law founded upon his case is hardly very sound law.

Q. DR. WISE: I have another one which is rather long. And it is as follows. Lawyers find it well nigh impossible to obtain medical testimony in suits against other doctors for gross negligence or malpractice. What does the medical panel think of the medical ethics wherein doctors protect each other in this manner rather than being eager to testify against other doctors for such malpractice?

MR. MACMILLAN: Question objected to. (Laughter)

DR. WISE: Objection sustained. (Laughter)

MR. MACMILLAN: That is getting right on our toes.

DR. WISE: I might say in that regard that any suit or threatened suit is discussed by the Council of the Medical and Chirurgical Faculty, and doctors that the Council thinks guilty of malpractice are not protected, certainly in the sense described here. I think that is an unjust accusation.

Q. What are the recognized methods of definitely determining whether or not a patient has a ruptured disc?

DR. WISE: That is a medical question, and I don't think Dr. Eaton wants to go into medical diagnosis here. I think that is definitely a medical question and it is out.

Q. How can doctors maintain that they are able to state an industrial disability percentage when most have not any follow-up study experience?

DR. EATON: I think that there are so many disability evaluations that if a doctor peruses even a small proportion, he will end up by being confused. That was my own experience when I started in practice, I can tell that some of my elder and wise colleagues have told the court and testified that their opinion as to the man's dis-

ability is on the reduction of that man's earning power.

Now, Mr. Coughlan brought up the question that you could examine an eye or ear, and group it into percentages, but could you do it with any other part of the body? There is no question but what the eye and ear are most susceptible to such grouping, but head injuries, abdominal injuries and spine injuries are so unsusceptible to such grouping that it would be out of the question. The expert witness is bound to give his estimate, his opinion on how much a man's earning power is cut down. I don't believe there is any formula that can be worked out to a better advantage.

DR. WISE: I have other questions here, but the answers to them have been covered, I think, in the main papers and in the discussion. It is now nearly 10:30, and unless there is something else—would you like to ask a question?

Q. MR. AMOS I. MEYERS: Judge Smith, as a trial lawyer interested in the evaluation of disability, I know that most of the trial lawyers on both sides of the fence have difficulty when they find doctors going into the realms of evaluating industrial disability. Don't you think they ought to limit themselves to anatomical and surgical disability, and to leave it to the layman to interpret, as they do in the State Industrial Accident Commission, and limit the doctors to stating the

anatomical or surgical disability? The Commission under the Workmen's Compensation Law interprets that in loss of earning or loss of industrial use.

In other words, I think that the average doctor, while he does read books, we assume, does not have a follow-up study of any particular type of injury related to a particular type of occupation. For that reason, we trial attorneys frequently, both for the insurance carrier and for the claimant or the plaintiff in a case, feel that the doctors go a little too far frequently in trying to interpret industrial loss of use instead of limiting themselves to their surgical experience.

DR. WISE: I take that as a discussion and not a question.

MR. MEYERS: It is a question that I asked.

DR. WISE: To whom is it directed?

MR. MEYERS: To Dr. Eaton. I was posing that question to him, because Dr. Eaton had answered the other one.

MR. MACMILLAN: That is a good illustration of a hypothetical question. I took a half day on one of them.

DR. WISE: I think the Chair would like to rule that as being a discussion. If there is no further discussion, I move that we call the meeting adjourned.

ABSCCESS OF THE LUNG DUE TO ENDAMOEBIA HISTOLYTICA TREATED BY SURGERY AND AUREOMYCIN*

MILTON GINSBERG, M.D. AND JOSEPH M. MILLER, M.D.†

In a comprehensive review of the pleuropulmonary complications of amoebiasis, Ochsner

* Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors are the result of their own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

† Veterans Administration, Fort Howard, Maryland.

and DeBakey¹ reported that the great majority of instances of pulmonary involvement are secondary to hepatic disease. An abscess forms in the liver and ruptures through the diaphragm. Of a total of 168 cases of pleuropulmonary amoebiasis, only 22 patients with a pulmonary abscess did not have hepatic amoebiasis. One

instance was supposed primary in the lung while the other 21 were due to embolism from the colon. The amoeba gain entrance to the portal vein from the colon, pass through the hepatic veins to the inferior vena cava and then go on to the lung. A second route is through the hemorrhoidal veins directly to the inferior vena cava and then to the lung. Ochsner and DeBakey also suggest that the amoeba may enter the

the present instance it was made only upon microscopic examination of tissue after operation.

CASE REPORT. W. M. T. (R-27548), a 34 year old negro, was admitted to the medical service of the Veterans Administration Hospital on May 26, 1949 with chief complaints of progressively more severe cough, hemoptysis, and a loss of 25 pounds in weight over a period of six months. A dull, aching pain, aggravated by coughing, was present in the right anterior portion of the thorax.

A roentgenogram of the thorax, taken elsewhere about one month after the onset of his illness, was reported to be normal. About two months prior to admission to the hospital, slight cloudiness was seen in the right upper chest on a roentgenogram made at a second clinic. Numerous specimens of sputum were examined for tubercle bacilli during this period and were found to be negative.

During World War II, the patient had served in India for about one year. For a period of two years, he had worked as a laborer in his local sewerage department. His duties often necessitated dislodgement of fecal material which had clogged drainage pipes. The patient does not remember episodes of abdominal pain, diarrhea or bloody stools prior to his present illness.

Physical examination was not contributory. The lungs were resonant and clear throughout.

Repeated roentgenograms (Fig. 1) of the thorax showed an abscess in the right lower lung field. Examinations of the sputum for tubercle bacilli and tumor cells were negative. A mass, ulcer or point of hemorrhage in the tracheobronchial tree was not found when bronchoscopy was done, although a large amount of purulent secretion was aspirated from the bronchus to the lower lobe of the right lung. Microscopic examination of stained specimens of the secretion and inoculation of the material into a guinea pig did not offer diagnostic help. The administration of large amounts of penicillin and sulfadiazine, multiple transfusions and postural drainage did not produce improvement.

The patient was subsequently transferred to the surgical service where bronchoscopy was repeated without discovery of a cause for the persistence of the abscess. Continued expectoration of large amounts of hemorrhagic purulent sputum in the absence of fever indicated that free communication between the cavity of the abscess and the bronchus existed. The persistence of an abscess of unknown etiology, apparently adequately treated, invited exploratory thoracotomy and whatever additional surgical procedure was indicated.

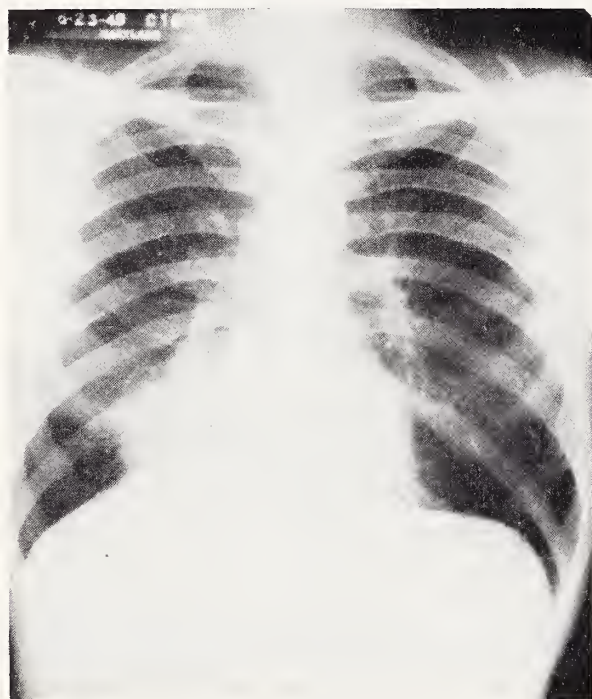


FIG. 1. Roentgenogram of the thorax showing lesion in right lower lung field.

thoracic duct, be carried to the left subclavian vein and then on to the lung.

Abscess of the lung due to *Endamoeba histolytica* simulates common lesions of the lung. Profuse purulent expectoration, occasionally hemorrhagic; respiratory distress and intermittent elevation of temperature are present. The signs are those of bronchopneumonic consolidation and later of abscess. *Endamoeba histolytica* is usually not found in the sputum. The roentgenogram of the lung does not offer aid in diagnosis.

Establishment of the diagnosis is difficult. In

The right thorax was entered through the bed of the resected seventh rib. A moderate number of adhesions connected the lower lobe and the diaphragm. An aperture was not present in the diaphragm and a fistula between the liver and the lung was not found. A firm mass about nine cm. in diameter was present in the upper portion of the lower lobe and the inferior portion of the middle lobe. Resection of the middle and lower lobes, using the individual ligation technique, was done. Provision for underwater drainage of the pleural cavity was provided.

When the specimen was sectioned by the pathologist, a cavity measuring 5 by 4 by 2 cm. was demonstrated in the upper portion of the lower lobe and the inferior portion of the middle lobe of the right lung (Fig. 2).



FIG. 2. Cavity in upper portion of lower lobe and inferior portion of middle lobe of right lung.

Thick, mucoid and slightly translucent exudate was present. Trophozoites of *Endamoeba histolytica* containing erythrocytes (Fig. 3) were found easily on microscopic examination.

After establishment of the diagnosis and with a normal preoperative electrocardiogram, a course of emetine was started, 0.06 gram being given subcutaneously daily. After five injections, a paroxysmal supra-ventricular tachycardia started. The drug was stopped and the electrocardiogram reverted to normal. Aureomycin grams 1.5 divided into 6 doses was given the first day. The amount was then increased to 2.0 grams per day in eight doses for about the next month. Subsequently for about 4 weeks, the patient received 1.0 grams per day in 4 doses. The response to aureomycin was excellent.

Evidence of a bronchopleural fistula became manifest in the postoperative period. This complication necessitated subsequent open drainage and later a plastic procedure. One stool only was found to contain trophozoites postoperatively, although many examinations were made. A roentgenogram of the colon after the administration of a barium enema was normal. The patient was discharged on October 31.

On December 12, the patient stated that he was well. The roentgenogram of the chest showed a density over the previous area of the lower lobe of the right lung but the remainder of the lungs was clear. On May 8, 1950,

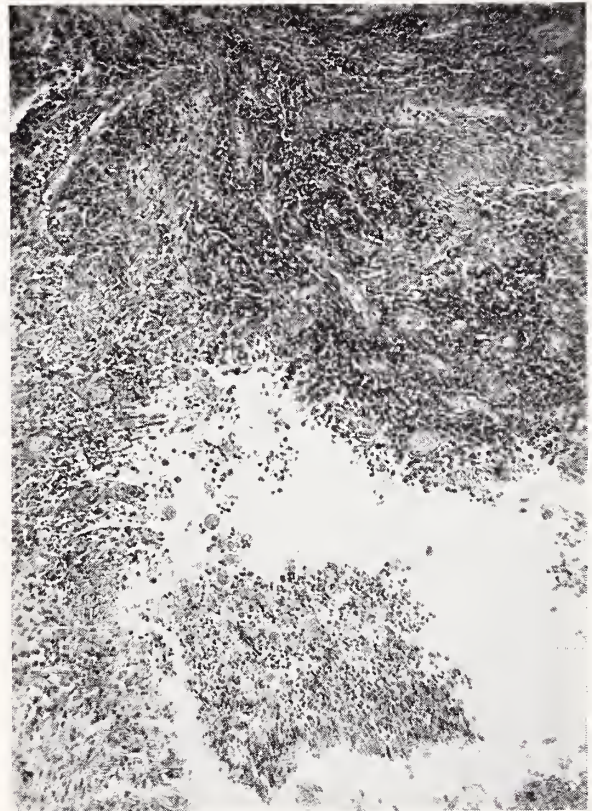


FIG. 3. Microscopic field of exudate showing *Endamoeba histolytica*.

the patient was well and the roentgenogram of the chest was the same. On November 6, the patient stated that he was well and the roentgenogram of the chest had not changed.

COMMENT

The presence of a chronic pulmonary abscess which has free drainage, from which tubercle bacilli and tumor cells cannot be isolated and

which does not respond to the usual measures of treatment, should invite specific search for *Endamoeba histolytica* in the sputum. If the amoeba is not demonstrated, a therapeutic trial of emetine or preferably aureomycin might be indicated. The hazard of subsequent surgical procedures for the abscess, where necessary, will

be materially decreased. The response to aureomycin was excellent in this instance and confirmed reported results.

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DOCTORS NEEDED FOR MARINE CORPS RESERVE UNIT

The recently organized First Engineer Battalion, USMCR, at Fort McHenry, Baltimore 30, Maryland, is offering an exceptional opportunity to Doctors of the Navy Reserve. This unit is authorized two reserve doctors. Membership in the unit will afford doctors an opportunity to earn retirement and promotion credit points and will not in any manner effect their status in regards to active duty. However, for those doctors who do not desire to attend the two weeks summer training camp at Camp Lejeune, North Carolina, but who desire to affiliate with this unit, there is now offered the status of Appropriate Duty. In an Appropriate Duty status a doctor receives all the same benefits, but is not considered a member of the unit and will not attend summer camp.

Any Navy Reserve doctors interested in this opportunity should either telephone Lieutenant Colonel E. P. Moses, Jr., USMC, at PLaza 4132 or see him personally at Fort McHenry in Building 1.

SOCIETY FOR THE PREVENTION OF ASPHYXIAL DEATH

A patron of the Society for the Prevention of Asphyxial Death Inc., interested in making the causes and prevention of asphyxia better known among physicians of Maryland State, has kindly offered to donate a copy of the *Art of Resuscitation*, by Paluel J. Flagg, M.D., to the first 100 physicians who become members of the Society following the release of this information in the Medical and Chirurgical Faculty of the State of Maryland.

Volumes donated will be autographed by Dr. Flagg. The book lists for \$6.00. Dr. Chevalier Jackson says, "To learn from this book means to save human lives."

Physicians who wish to receive this autographed volume for their library are asked to apply for membership in the Society for the Prevention of Asphyxial Death Inc., enclosing membership dues of \$5.00. Communications should be addressed to, Secretary, S. P. A. D. Inc., 2 East 63rd Street, New York 21, New York.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.,
Journal Representative

The Memorial Hospital in Cumberland has recently reorganized its Tumor Clinic, to conform as closely as possible with recommendations made by the American College of Surgeons.

The general purpose of the Clinic is the examination of patients referred to the Clinic and the recommendation of treatment to the referring physician. No treatment is given in the Clinic unless a specific request is made by the referring physician.

The Clinic is held every two weeks, on the 1st and 3rd Thursdays of each month, at 9:00 A.M.

THE BALTIMORE CITY MEDICAL SOCIETY

SAMUEL McLANAHAN, M.D., *President*

According to the Constitution and By-Laws of the Baltimore City Medical Society, meetings are held monthly from October through April. The programs throughout the past winter and spring proved extremely worth-while and were, for the most part, well attended. The Program Committee has already outlined plans for the coming fall meetings.

The various Sections have been active, and their meetings have proved of great value to those attending.

At the meeting of the Baltimore City Medical Society on April 18th, a new section was formed to be known as the Cancer Section. The formation of this Section, already noted in the May issue of the JOURNAL, should prove to be a welcome addition to the other Sections of this Society. If properly developed it can form a common meeting ground for those interested in malignant disease from the standpoints of research and of therapy in its various aspects.

OPHTHALMOLOGICAL SECTION OF THE BALTIMORE CITY MEDICAL SOCIETY

ANGUS L. MACLEAN, M.D.*

At the second winter meeting of the Ophthalmological Section two papers were presented—one on the "Present Status of Beta Irradiation in Ophthalmology," by Dr. Charles E. Iliff, and another on "Vertical Ocular Deviations," by the guest speaker, Dr. Harold Brown of New York City.

Dr. Iliff stated that Beta Irradiation is ideally suited for the treatment of certain lesions of the anterior ocular segment. He stated that the success of this treatment depended largely on the clinician's thorough understanding of the basic principles of irradiation, and a complete knowledge of the potentialities and dangers of the applicator used.

The three types of beta-ray applicators—the radon, the radium salt, and the strontium—now in common use were demonstrated and the advantages and disadvantages of each described. A safe and effective dosage of beta-ray for anterior segment lesions was given, likewise the number of applications usually necessary and the time interval between treatments.

Dr. Iliff presented photographs of a number of ocular conditions before and following beta irradiation therapy. Dramatic results have been obtained from this treatment in both bulbar and palpebral vernal conjunctivitis. Here, however, irradiation must be used as a supplement to and not as a replacement for anti-allergic therapy. Small benign tumors of the lids and the anterior ocular segment can be removed with rapidity and ease with these rays and the cosmetic result is excellent. In treating malignant lesions, beta irradiation may be used alone or as an adjunct to surgery. New corneal vascularization can be controlled and existing vessels occluded. At times, this may produce an improvement of vision rendering a contemplated corneal transplant unnecessary. Furthermore, oc-

* Secretary-Treasurer.

clusion of the corneal vessels increases the chances for a successful transplant. Corneal scars in which vascularization is a prominent feature become less dense after beta irradiation. Growth of a small pterygium can be inhibited by irradiation near the limbus and recurrence of a pterygium can frequently be prevented by one application just external to the limbus at the time of surgical removal. The course of tuberculous sclero-keratitis has been shortened and the severity reduced, resulting in less corneal damage. In summary, beta irradiation offers to the ophthalmologist a means of treating many lesions for which no satisfactory therapy previously existed.

Dr. Brown discussed the different types of vertical ocular deviations. He stressed the importance of diagnosing carefully the underacting muscles but more particularly of determining the overacting muscle or muscles playing a part in any vertical deviation. He furthermore stressed the importance, when the time comes for surgery, of weakening the overacting muscle rather than attempting to strengthen or shorten by resecting the paretic muscle. For the dissociated or alternating types of hyperphoria, he stated that any horizontal deviation should always be corrected to improve the cosmetic appearance but that as little surgery as possible, or none at all, should be performed for the vertical deviations. In cases of double elevator paresis where both the inferior oblique and the superior rectus of the same eye are involved, contracture of the inferior rectus, resulting in what is usually described as the retraction syndrome, has frequently been found. Recession or tenotomy of the muscle causing the retraction will usually correct this anomaly completely. A number of unusual types of ocular muscle paralysis were cited. In one a paralysis of the sixth nerve resulted from a blow to the opposite side of the head. Dr. Brown was at a loss to explain the origin of this contralateral paralysis and could offer no satisfactory course of treatment.

The third meeting of the 1951-52 Winter Session of the Ophthalmological Section of the Baltimore City Medical Society was a joint dinner meeting with the members of the Washington Ophthalmological Society and was held at the Sheraton-Belvedere Hotel. It started with cocktails at 6:00, dinner at 7:00, and the scientific session at 8:00 P.M.

Following a very delightful dinner, the meeting was called to order by the President, Dr. Abraham Kremen, in the chair. The report of the Nominating Committee was read by Dr. Knowles. The names proposed for new officers of the Section for 1952-53 were as follows: President, Dr. Angus MacLean; Secretary-Treasurer and Vice President, Dr. G. C. Dix; Program Committee, Dr. Wm. C. Owens, Dr. Charles E. Iliff, and Dr. Ernest Bodenheimer. As there were no further nominations, these were declared duly elected.

Dr. Kremen read a letter from Dr. William Benedict, Secretary General of the XVII International Congress of Ophthalmology, scheduled to meet in New York, September 12, 1954. Dr. Benedict asked if our Society would be willing to participate in some planned program and entertainment for visiting Ophthalmologists from foreign countries who will be in attendance at the meeting of the Congress at that time.

The first speaker of the evening, Dr. Ronald Wood, was then introduced by the Chairman. The subject of his paper was "Principles of Hypersensitivity and Desensitization". The following outline was used by Dr. Wood in his talk.

Hypersensitivity

Definition—The changed state of the body resulting from contact with "foreign" substances of certain types.

Classification

1. Type of sensitivity
 - a. The Anaphylactic state
 - b. The Arthus type
 - c. The Pollen type
2. These manifestations are due to the following differences:
 - a. The route of entry of the antigen
 - b. The amount of antigen
 - c. The response of the individual
 - d. The character of the antigen
3. The Bacterial type of hypersensitivity may be distinguished from anaphylactic, arthus, and pollen types by:
 - a. Delayed cutaneous response (24-48 hours)
 - b. Firm induration
 - c. Delayed systemic reaction
 - d. Focal reactions
 - e. Not transferrable by serum
 - f. Cell sensitivity remains in tissue culture
 - g. Established only by contact with whole living or dead organisms
 - h. Body reacts to either intact organisms or soluble proteins from it

- i. Commonly present in the absence of anaphylactic type of sensitivity
- 4. Some properties of antigens:
 - a. Large molecular weight
 - b. Usually colloidal—particle size important
 - c. Usually proteins, may be carbohydrate or lipid antigenicity of different substances vary
 - d. Usually substances foreign to the *circulation*
- 5. Some characteristics of antibodies:
 - a. One antibody may have several demonstrable effects, i.e., the Unitarian theory
 - b. Chemically indistinguishable from normal globulins
 - c. Specificity extremely marked but not absolute

Desensitization

Methods:

- 1. Large injection of antibody—dangerous
- 2. Repeated small injections

Results:

- 1. Temporary in anaphylactic type usually
- 2. Temporary or permanent in the bacterial type

Non-Specific Desensitization:

- 1. Anaphylactic shock inhibited by many agents, i.e., inorganic salts, proteins, etc.
- 2. Bacterial hypersensitivity removed by apparently unrelated organisms (Wide distribution of antigens may partially explain)
- 3. Non-specific desensitization less effective and constant than specific

Mechanisms of Desensitization

- 1. Neutralize antibody—i.e., removal on exhaustion
- 2. Interfere with the reaction, i.e., prevent antigen reaching sensitive tissues
- 3. Alter the tissue susceptibility, i.e., drugs and hormones such as adrenalin, ACTH, and Cortisone

This paper was discussed by Dr. Alan C. Woods and Dr. Jack Guyton. Dr. Woods expressed the thought that the ideas contained in Dr. Ronald Wood's paper probably represented the important features of future medical and ophthalmological trends. He stated that there was, of course, a great deal more in Dr. Ronald Wood's paper than probably anyone at the meeting could digest in such a short time but that it contained a very concise and workable summary of the entire subject of hypersensitivity and desensitization and that Dr. Wood was to be congratulated for this excellent presentation. Dr. Guyton's discussion was along similar lines.

Dr. Kremen then called upon Dr. Leslie Harrall Pierce to introduce the guest speaker of the evening. Dr. Pierce gave a very interesting summary of Dr. Schepens's life history. He was born and educated in

Belgium, and spent much time in post-graduate work at Moorfield's in London. He was invited to this country by Dr. Arnold Knapp and asked to demonstrate his ophthalmoscope and present his ideas on indirect ophthalmoscopy at the 1946 meeting of the Academy in Chicago. After that, he became associated with the Massachusetts Eye and Ear Hospital and later started the Retina Clinic in Boston.

Dr. Schepens gave a most interesting talk on retinal detachment. He showed a moving picture of his method of indirect ophthalmoscopy together with his technique of scleral indentation for better exposure of retinal tears in the region of the ora serrata, an area which previously direct ophthalmoscopy had been unable to reach. The etiology of retinal tears and detachment and their possible relationship to biochemical and pathological changes in the vitreous was discussed. His method of treatment was then described. He has made more use of surface diathermy and much less of penetrating punctures than has been employed by other ophthalmologists. A unique instrument, combining electrical illuminating and cauterizing features, for accurate scleral localization of small tears at operation was demonstrated.

A number of interesting points were clarified in discussions and questions by Drs. Guyton, MacLean, Iliff, and Woods.

BALTIMORE COUNTY MEDICAL SOCIETY

DONALD L. SOMERVILLE, M.D.,
Journal Representative

Recently the Baltimore County Medical Society met at the Sheppard-Enoch Pratt Hospital. As usual, our hosts for luncheon served a very pleasing meal, preceding the business and scientific session. The members heard with interest the report of the Medical Care Committee, wherein legislative reduction by \$50,000 in the Medical Care budget was discussed and considered. The committee members viewed this cut in funds with natural alarm, and various suggestions as to how to cope with the situation were offered, none of which seemed satisfactory.

The scientific portion of the program was introduced by the Director of Enoch-Pratt Hospital,

Dr. H. M. Murdock; Dr. Richard Kenworthy of the hospital staff gave a very interesting and informative resumé of the present day status of insulin therapy in psychiatric disease; his colleague and fellow staff member, Dr. John Patton, concluded with a similarly comprehensive dissertation on electro-convulsive therapy.

The Baltimore County Medical Society has inaugurated the idea that its membership should be open to dentists of the county, and the members are being encouraged to invite dentists of their acquaintance to join as associate members; this would seem to have at least a two-fold purpose: the dentists may become more closely associated with each other—inasmuch as there is no dental society in the county—and also, of course, should thus become more integrated with the county physicians. It is believed that this relationship between the two professions should be mutually quite desirable and instructive.

WASHINGTON COUNTY MEDICAL SOCIETY

W. D. CAMPBELL, M.D.,
Journal Representative

FLUORIDATION OF WATER

The Washington County Medical Society joined the Washington County Dental Association requesting the fluoridation of the local water supply.

There seems to be ample evidence appearing in the literature to prove fluoridation gives protection against dental caries without causing any harmful physical effects.

Treatment of the water has been in operation several months.

WASHINGTON COUNTY MEDICAL UNITS GET READY FOR GERM WARFARE

Medical authorities are getting ready for possible biological or germ warfare as well as conventional bombing attacks.

A team of auxiliary sanitarians is being recruited for duty here in case of germ warfare. These sanitarians would help professional medical authorities in making water tests and in using other detection devices. Auxiliary sanitarians are being recruited at

present from the ranks of the Junior Chamber of Commerce.

Meanwhile, considerable progress in organizing civilian defense medical units for handling casualties in possible bombing attacks here has been made.

Plans have been made to quickly expand hospital facilities in this city to 1,826 beds in case of disaster. Two buildings in other parts of the city would be set up as temporary hospitals to supplement the Washington County Hospital.

Two casualty clearing stations would be set up, one at Antietam Street School and the other at Fountaindale School. Three other stations would be set up out in the county: one at Hancock, one at Williamsport, and one at Boonesboro.

Fifty-one doctors, twenty-six dentists, fifteen pharmacists and one hundred forty-four nurses have volunteered their services for casualty station duty.

What is needed now are large numbers of volunteer non-professionals to provide manpower to move casualties to and from the clearing stations.

COSTS AT HOSPITAL DOUBLED IN FIVE YEARS*

The cost of keeping a patient in the Washington County Hospital more than doubled during the period from 1945 to 1950 but the cost is still below the national average. In 1945 it took \$5.36 per day to keep a patient in the county hospital, while in fiscal 1950, ending in September of that year, the cost was \$12.07 per day.

These figures are arrived at by dividing the total expenses of the hospital by the days of hospital care. In 1945 there were 5,971 patients while 7,975 were treated in 1950. The number continues to climb since 8,665 patients were handled from September 1950 to September 1951, with 62,327 days of hospital care.

J. Tally Good, administrator of the Washington County Hospital, believes that local hospital costs are below the national average.

A comparison of local and national costs can be seen in the statement of Dr. Morris Fishbein, former editor of the *Journal of the American Medical Association*. He recently said that ten years ago it took about \$10 per day to keep a patient in a hospital. Today, he said, it takes \$15.62.

* From: The Morning Herald, March 26, 1952.

At the Washington County Hospital, it cost \$4.85 in 1940 for daily care and way back in 1905, \$3.45. During those years the number of patients increased from 106 to 3,500 in 1940.

Present day rates per day in the county hospital range from \$6.50 for the wards to \$8.50 for a two-bed semi-private room to \$13 for private rooms with toilet and bath.

HOSPITAL PLANS TO OPEN NURSERY SO MOTHERS CAN RETURN TO DUTY*

The Washington County Hospital will try to relieve its nursing shortage by providing a day nursery for children of staff members while the mothers are on duty at the hospital.

Hospital administrator J. Talley Good, in announcing the plan, said there is a considerable number of nurses in town who are prevented from serving on the hospital staff because they must care for their young children. Many of these would return to active duty if suitable arrangements could be made for the youngsters during the working day.

The board of trustees has approved the idea, Good said, and the hospital's building committee has taken up the job of planning for the project.

It is planned to have the nursery located in the former nurses home adjacent to the main hospital building. The three story structure was originally the home of the president of Kee Mar College, when that institution occupied the ground where the hospital now stands.

During the construction of the new hospital wing, the building has housed the pediatrics department. Patients will be moved from here as soon as the facilities in the addition are available.

While their mothers are on duty at the hospital, the children will be supervised by nurses aides and student nurses. In this respect it was pointed out that student nurses must observe and care for healthy children as part of their training, so that the nursery will also become a valuable part of the program of the School of Nursing.

It is not known how many nurses will be added to the staff through the establishment of the nursery, but Mrs. J. Earl Knott, Jr., president of the Nurses Alumnae Association, says that a considerable number have shown interest in the idea. Miss

Julia R. Lizer, the hospital's director of nursing, reported that a preliminary survey disclosed that 60 per cent of the nurses contacted indicated that they would return to duty if the nursery was made available.

MEDICAL SCIENCE CLUES MIGHT BE LOCATED HERE*

Hagerstown might contain clues which would reveal to medical science the relationship between long-term diseases and families.

The United States Public Health Service has studied Hagerstown, as a typical United States city, for many years, gaining much insight into ill health and its effect on people here. As a result, health authorities—both here and elsewhere—would like to see the studies expanded.

Research done here in the past reveals that there is some relationship between the family and the presence of diseases like heart trouble and cancer. Put into technical language, the proposed research would attempt to:

1. Determine the familial factors related to health and illness, with particular reference to diseases and disabling conditions of long durations and gradual onset.
2. Develop techniques to identify and measure familial factors and their relationships, and to apply effective measures to improve family health services and family health.

The Washington County Medical Society some time ago pointed out to the USPHS that information already gathered here "offers the basic material necessary for the solution of many more problems of practical importance." It passed a resolution urging continuance of this work.

Congress also has looked with interest on the idea. Rep. J. Glenn Beall submitted a resolution to the House several years ago, seeking more research on this topic. A similar resolution was presented by then Sen. Millard Tydings and passed the Senate.

The Public Health Service likes the idea, too, and says its work has been limited only by lack of funds. One high USPHS official said:

"Much of the success already achieved in controlling, and in some cases virtually eradicating, infectious diseases such as typhoid fever, tuberculosis, and diphtheria stems from knowledge gained through investigations on family and environ-

* From: The Morning Herald, February 14, 1952.

* From: The Morning Herald, February 15, 1952.

ment—leading to a more precise understanding of the patterns in which diseases spread and laying a foundation for the prevention of transmissible infections.”

Dr. Perry Prather, county health officer, testified at a hearing in Washington on the project:

“The medical profession now knows that a sick individual must be looked at as part of a family which is at the same time a social and biological unit. . . . Each family has its own pattern and it is different just as individuals are different. We should have methods by which to study and treat families that have a sick member, just as we study and treat individuals that have a diseased organ.”

HOUSE PASSES BILL FAVORING PHYSICIANS AND OTHER SKILLED IMMIGRANT APPLICANTS

Capitol Clinic, A. M. A., Bulletin No. 49—82nd Congress, May 1, 1952

The House April 25 passed a bill drastically revising the Nation's immigration laws. The bill (H. R. 5678) introduces a high degree of “selectivity” in choosing between applicant immigrants. The first 50% of the quota of each country annually would be made available to qualified quota immigrants whose services are determined by the Attorney General to be needed urgently in the United States because of the high education, specialized experience, or exceptional ability of such immigrants, and to be substantially beneficial to the national economy, cultural interests, or welfare of the United States. This group of skilled persons (including physicians) and their families would be given preference over alien parents of citizens of the United States and qualified quota immigrants who are spouses or children of aliens lawfully admitted for permanent residence in the United States. Unfilled quotas from other than the skilled person group could also be used to admit persons in the skilled category.

MARYLAND STATE POLICE

Dr. Howard M. Bubert, physician of the Maryland State Police, has sent the Medical and Chirurgical Faculty a copy of the interim report of the Ambulance Activities of the Maryland State Police Department and its Allied Organizations, for the six month period from July 1, 1951, to December 31, 1951.

Dr. Bubert states that due to numerous requests and the revision of their report system, they are changing from a fiscal year basis to a calendar year report.

He believes that the Ambulance and Rescue Squad Activities are a real contribution to the medical care of the citizens of the state.

The interim report is filed in the Faculty Library if the members wish to see it.

Library

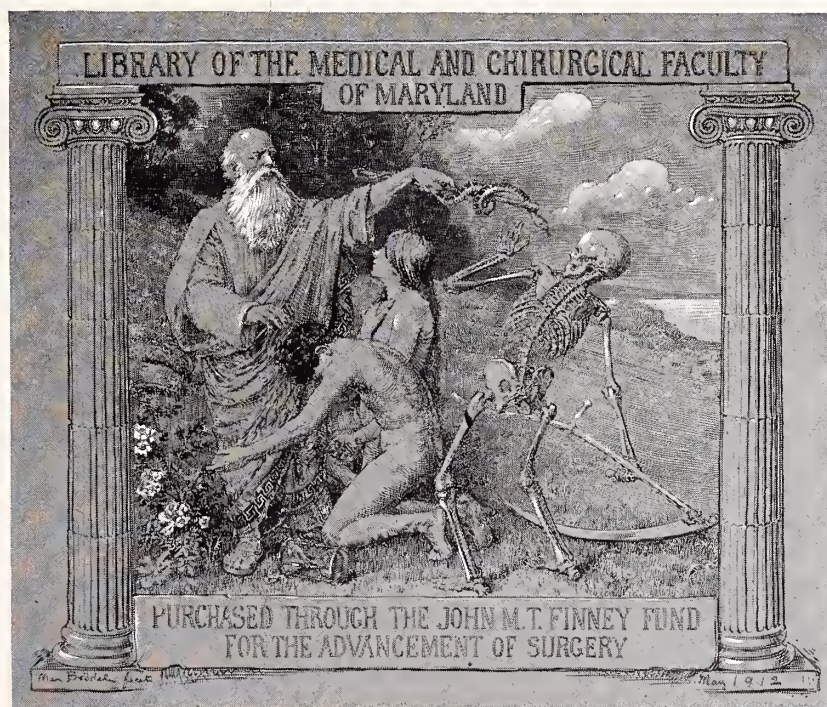
BOOKPLATES—THE FINNEY FUND

PAULINE DUFFIELD

In January of 1912 news was received by the medical profession of Maryland that Dr. John M. T. Finney had declined the presidency of Princeton University, and would remain in Baltimore in the practice of his chosen profession. The Finney

In three months there were two hundred thirty-seven subscribers and a total of ten thousand dollars (\$10,000) collected. Dr. Harry Friedenwald acting as spokesman for the Committee presented the fund to the Faculty at the annual meeting on April 23, 1912.

As stipulated in the agreement the income from the Fund was to be used to procure lectures and for



FINNEY FUND BOOKPLATE

testimonial committee was formed to honor this outstanding surgeon.

The committee at first thought of a portrait, but upon further consideration it was felt this would not be suitable either to the occasion or the man, for they sought some testimonial that would be a lasting memorial. The idea was conceived to create a permanent fund for the advancement of surgery to be known as the "JOHN M. T. FINNEY FUND FOR THE ADVANCEMENT OF SURGERY" and the beneficiary should be the Medical and Chirurgical Faculty.

the purchase of books, monographs and journals for the library, providing that the lectures, books, monographs and journals be confined to surgery in its broad sense, including general surgery, surgical anatomy, surgical pathology and surgery of the various organs, thus embracing gynecology, genito-urinary surgery, ophthalmology, otology, rhinology and laryngology and other special branches of surgery.

The agreement stipulated that a special and permanent committee of five be elected by the House of Delegates to manage the fund and to

apply the income as stated. The Finney Fund consisting of five members meets with the Library Committee. One member is elected each year to serve for five years. Dr. Louis Hamburger a member of the original committee is today a member of the committee.

The agreement also states that the name of Dr. John M. T. Finney be associated with all lectures to be delivered under the auspices of the committee and all books, monographs and journals purchased with the income of the fund be marked, "Purchased by the John M. T. Finney Fund for the Advancement of Surgery."

The Finney Fund bookplate was designed by the late Max Brödel to carry out the wishes of the committee.

HINTS FOR MEDICAL WRITERS

As one reviews the history of medicine, it may be said that medical journalism began over six thousand years ago. This fact is made clear in many of the relics of antiquity that have come to us through the ages. In the early records of medicine, there is at least one Babylonian tablet, dated earlier than 4,000 B.C., which reported a case of incurable dropsy. Then, in the Aesculapian temples, there are the tablets which may be considered to be collected medical records. Often, these tablets gave records of the therapeutic treatment, observations and the results of medical cases.

In view of the many historical records, one wonders if there was as much criticism over the way a case was recorded in 4,000 B.C. as there is today. At the present time, doctors are criticising doctors and the lay medical writers are spending time in judging poor sentence structure, choice of words and grammatical errors. Many critics forget that the essential purpose in writing a scientific paper is to share worthwhile information with people of like interests. In recording such information, doctors are providing a written record of doctors for doctors. It is assumed that, in such written records, the writer knows more about his subject than anyone else. If there is a genuine desire to write a paper, one has created the stimulus for study; for, to write a good medical paper, one must study.

Many papers that have been given before local

medical groups have been received with so much enthusiasm that the group requests the paper to be printed. As a speaker, you should never submit your speech for publication until it has been rewritten. It may be a timely subject for a local group, it may have local statistics and interest; but, to the general reader, it may have been overworked in the literature and the statistics will not apply to the country as a whole. The personality of a speaker may make a success out of a poor paper; but, this personality cannot be relayed to the reader and the entire paper may be nothing but cold type. The publication of a good medical paper is an ethical way to advertise. To speak before a group, one's work becomes known to a few; but, to write a good paper, the work is known to hundreds. Scientific writing is an exact science and should be treated as such. There is no place for colloquial or slang expressions. Correct English is a very important must. Perhaps, one will say he cannot write. With all of the aids that have been published over many years, it has been shown that any one can write if he will study. You may have to write and rewrite and make many drafts of a paper; but, eventually, one is able to express to the reader his thought in an interesting and an informative manner.

In order to make easier the task of composing a paper, it is essential to draft an outline of your material with the following necessary points.

I. TITLE

Every article worth publishing is worthy of a proper title.

Dr. Billings said many years ago, "Every article which is worth printing is worth a distinct title, which should be as concise as a telegram."

The title must tell exactly what the article is about. Avoid any terms which do not represent something definite. Do not coin new terms for old ones. Words are labels and your title is the label on your paper.

Be descriptive but be as brief as possible.

II. INTRODUCTION

The introduction should state the purpose, nature, content, reasons for the investigation and the scope of the material to follow.

It may be necessary to give a historical review of the subject in the introduction. Today, many writers are using only references to the historical literature that refer to the subject, thus avoiding a long introduction.

III. BODY OF THE PAPER

The body of the paper should explain, in logical order, the facts presented in the introduction. All material must be given in a clear and systematic

arrangement. The facts, theories and deductions should be easy for the reader to comprehend.

Do not repeat material in the text that has been given in charts, graphs or tables, unless necessary. Every illustration should save words and tell a story. Link each part of the paper with some preceding part, so as to make a continuous story.

Include the amount of material investigated, new methods and, if necessary, old methods.

A discussion of the results and findings of a negative character should also be stated.

Guard against misunderstanding of language.

Define clearly the points. Do not ignore or evade the point.

Do not base a conclusion on an unproved proposition. Avoid all details that are not essential for accuracy and completeness.

Brevity in writing may be the best insurance for its perusal.

IV. SUBHEADINGS

Use subheadings that will aid the reader and break up the solid page of type. They should be concise. Whenever, the subject is changed, a different heading must be added.

V. SUMMARY AND CONCLUSIONS

The summary should give the prominent facts as concisely as possible.

Many times the summary is used verbatim by abstractors. It is equally true that many readers will glance at the summary and if they find it interesting they will read the entire article.

Not all articles need to be summarized. Summaries are made only when articles have more than 1,500 words, or articles that have involved descriptions and techniques or when a complete review of the literature has been made.

The conclusions are the general statements of truths established in the article. They should be set forth at the close of the paper.

VI. NOTES OF ACKNOWLEDGMENT

Notes of acknowledgment are out of place in most scientific journals.

If a person has rendered a service of major importance, his name should be included with those of the author.

As: John B. Harvey
with the assistance of
Harvey B. John

VII. QUOTED MATERIAL

Quoted material requires that permission be secured from the author and from the publisher. The material must be quoted exactly.

VIII. BIBLIOGRAPHIES

Readers often wish that writers would give true and accurate references.

Do not use references which you have not seen as part of your bibliography.

Before presenting a paper to a journal, it is wise to check the bibliographical form in several of the recent copies of the journal to which you are sending your manuscript so as to be sure of the form required.

Now that you have completed your paper, you will await its publication. When you see what the editor has done to your paper, you will feel like Dr. MacLeod, the editor of the *MEDICAL GAZETTE*, which made its first appearance in 1827 with the prime purpose of killing the *LANCET*. In his first editorial, Dr. MacLeod said, "A few years ago, a set of literary plunderers broke in on the peace and quiet of our profession. Lecturers who had spent their lives in collecting knowledge, arranging it for communication, and acquiring the difficult art of oral instruction, saw the produce of their lives suddenly snatched from them and published for the profit of others, with the additional mortification of finding what they had taken so much pains with disfigured by bad English and ridiculous and mischievous blunders."

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Insurance

MARYLAND HOSPITAL SERVICE, INC.

ALBION K. PARRIS*

The unprecedented growth of Blue Cross and the volume of its payments to hospitals has caused many persons to think of it as just a remarkably successful program for insurance against the cost of hospital care.

True, about one-fourth of the nation is enrolled. There are 850,000 members of the Maryland Plan alone. True, benefits to subscribers now exceed \$40,000,000 nationally. In Maryland alone last year they came to more than \$7,500,000.

But important as all of this is, we shouldn't overlook the basic purpose of Blue Cross which is (a) to make modern hospital care more easily available to the public and (b) to provide a stable source of income for the hospitals in the community.

The story of Blue Cross began in the Depression's darkest hour, when a nation of individuals struggling to pay the grocer and the butcher found it almost impossible to meet the cost of health care.

Our voluntary hospitals, morally bound to accept patients regardless of their ability to pay, were desperate for funds and threatened with the prospect of closing their doors.

The people of the United States had the finest hospital, medical and surgical facilities in the world. Yet, they were in danger of losing their benefits because the economics of health care had not kept pace with scientific developments.

It was then that hospital authorities, doctors and civic leaders together planned to seek a solution. They found it in the idea of paying hospital bills from a common fund established by small subscriptions paid by many persons in the community.

This movement became known as Blue Cross, and today 88 Plans in the United States, Canada and

Puerto Rico serve 41,000,000 members with the active cooperation of more than 5,000 community hospitals.

Blue Cross was the first effective approach to the problem of health economics, and it remains the only one in which responsibility for the program is shared by those who provide the services and those who receive them. Mutual interest is essential if we are to maintain high standards of health care and keep service charges at realistic levels.

Community hospitals have shared the responsibility for the Blue Cross program from the beginning, making it possible for the Plan to offer maximum value for the health dollars so invested.

Blue Cross could not have grown to its present level without the support and cooperation of the medical profession.

The continued success of this non-profit, voluntary health Plan is of great importance to the medical profession and depends upon its continued support.

Of paramount importance is the doctor's guidance of his patients in the proper use of Blue Cross benefits. The doctor decides when a subscriber needs hospital care. He prescribes the drugs and services rendered. He determines the number of days needed for proper treatment.

All of these decisions of the doctor are factors that influence the cost of hospital care and the amount of the subscription charges paid by the subscriber.

Vision and long-range planning are called for if Blue Cross is to solve the many remaining problems facing prepaid health care.

Blue Cross will continue to the common goal—even broader protection for as many persons as possible the voluntary way, at a price the great majority of Americans can afford to pay—if the doctors, the hospitals and the public continue to work together in the common purpose.

* Public Relations Officer, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

WORD FROM OUR NEW PRESIDENT —MRS. CHARLES H. WILLIAMS

Greetings to all Auxiliary Members! Another year of Auxiliary work is starting—I have looked forward to my part in it with anticipation and great humility. My job will be a big one and I must look to you for help and support.

Although the Auxiliary is still very young its accomplishments have gained recognition from the Woman's Auxiliary to the A. M. A.

This year of 1952 is a critical one for our Country as well as for the medical profession. It is a privilege as well as a duty for all doctors' wives to take the lead in their communities to get out the vote. This may be accomplished in many ways.

Good public relations are always necessary for physicians. The American Medical Association supplies us with many ideas in this field. Our County Fairs provide a good opportunity to distribute literature on what we are for as well as the things which we oppose. Our Nurse Recruitment Program and the Auxiliary's Nursing Scholarships are tangible evidence of our community service. Good publicity concerning these efforts will stimulate more young women to enter this noble profession.

Membership in this Auxiliary is possible only because you are the wife of a member of the Medical and Chirurgical Faculty. Take advantage of your status and assume the responsibility that goes with it. Become a member by sending in your dues today, and become active in Auxiliary work. No individual is too busy nor effort too small. Help your husband to help others.

We must always remember that our Component Auxiliaries comprise the State organization, and that only as such are we a part of the team as The Woman's Auxiliary to the American Medical Association.

Keep up the good work, and God speed you in all your endeavors.

ACTION TAKEN AT THE ANNUAL MEETING

The following Resolutions having been approved by the Council of the Medical and Chirurgical Faculty were passed by the Woman's Auxiliary to the Medical and Chirurgical Faculty at their Annual Meeting on April 30th, 1952, at the Stafford Hotel, Baltimore.

- I. Resolution (concerning closer Medical supervision of mentally or physically impaired drivers).
- II. Resolution (on Americanism, particularly in education).

I

WHEREAS, many physicians are concerned about the number of their patients who are automobile accident cases, and

WHEREAS, a closer medical supervision would seem imperative when mentally or physically impaired drivers are concerned, and

WHEREAS, the Woman's Auxiliary to the Medical and Chirurgical Faculty feels that this is a health and community problem needing further study by the medical profession, therefore,

BE IT RESOLVED, that the Woman's Auxiliary to the Medical and Chirurgical Faculty ask the Medical and Chirurgical Faculty of the State of Maryland to request the Honorable Theodore R. McKeldin, Governor of Maryland, to invite that body to appoint a committee to meet with the Medical Advisory Board to the Commissioner of Motor Vehicles in order to work out a better application form for drivers of motor vehicles, containing pertinent medical questions and carrying penalties for untruthful answers. Some reasonable means may thus be established to study individuals in whom there is a question of physical or mental incapacitation and, after proper investigation and study, to advise the Commissioner as to the disposition of

these cases. The present Medical Advisory Board, we submit, should in addition, be enabled to become more active and to expand its field of endeavor, and

BE IT FURTHER RESOLVED, that copies of this Resolution be sent to the President of the Medical and Chirurgical Faculty of Maryland.

II

WHEREAS, this country was founded on the principles of liberty and dignity for the individual, common to the Judao-Christian religions, and

WHEREAS, this principle resulted in developing a thrifty type of individual not afraid to work and willing to burn the midnight oil day after day, week after week, month after month, and year after year, because of the pride in the accomplishments resulting from his work, and

WHEREAS, this way of life developed a type of political philosophy resulting in the greatest industrial potential the world has ever seen, to say nothing of the accomplishments in pure science and the applied sciences, such as medicine, engineering, agriculture, there

BE IT RESOLVED, that the Woman's Auxiliary to the Medical and Chirurgical Faculty use all our influence to teach the principles upon which our country was founded, with their resulting accomplishments, in our homes, our schools, our churches, organizations, and everywhere, to the end that the flame of liberty may not be extinguished, and that our children and our children's children may have the benefits which our ancestors worked and fought for.

Our President Mrs. Charles H. Williams, will present these Resolutions to the National Auxiliary for consideration at their Annual June Convention in Chicago.

NOW IT'S UP TO US

MRS. R. WALTER GRAHAM, JR.,
Chairman, Medical Research

At the Annual Meeting in Baltimore some of us were lucky enough to see two excellent exhibits. The first which carried a label reading "sponsored by the Woman's Auxiliary to the Medical and Chirurgical Faculty," was an electrical question and answer box made for us by the Maryland Society for

Medical Research and patterned after one used with great success in Massachusetts. It was large enough to catch the eye, yet light enough for two women to carry easily. It had its own battery so no electrical connection was necessary. It asked such questions as:

1-A. The treatment for diabetes was discovered as a result of experiments on dogs. 1-B. Treatment for diabetes was developed solely from observation on humans. 2-A. Heart surgery is best learned by practicing the operation first on dogs. 2-B. Practice on dogs is of no use in heart surgery because the heart of dog and man are very different. If you push the correct button it lights up to show how smart you are, but if you push the wrong one. it gives a buzz rather like the "Bronx cheer." Since the questions are simply typewritten and inserted into position, they can of course be replaced by others of your own choosing. The box is primarily an attention getter and will attract people to our Auxiliary Health Booths at County Fairs this Summer. Once the audience is collected other American Medical Association literature can be distributed. If you can use this exhibit, write or call the Maryland Society for Medical Research, Mulberry 5348 or speak to Dr. Dietrich C. Smith. The Society will see that the exhibit reaches you but will expect to have it returned promptly. Since Dr. Smith will be away from July 25th, until September 1st, all arrangements for borrowing the exhibit should be made well in advance by the Component Presidents or their Medical Research Chairman. During Dr. Smith's absence from town the box will be kept at 1211 Cathedral Street and can be obtained there.

The second of the exhibits at the meeting was a film "Frontiers in Medical Research." It is beautifully done and fascinating to watch. It should interest the public in supporting research and in training for research careers. This film and an earlier one called "Anna Her Story" (the history of a dog used for research purposes and a great pet today at The Johns Hopkins Hospital) may be obtained without any cost whatever to your Auxiliary, just as the question and answer box. The films can be mailed to you and only the cost of mailing and insurance will be incurred. The Maryland Society also has access to the usual film library and can get films on the subjects of diabetes, cancer and so forth.

Perhaps your Auxiliary cannot take on a booth at a County Fair this Summer. Do not despair, you may be able to place speakers and films in schools. Training young people to an interest in medicine is one of our most important functions. The Maryland Society for Medical Research can supply you with interesting speakers to talk to students in schools or in churches or to civic or neighborhood improvement groups. If you will call they will arrange to take groups of as many as 30 or 40 people on tours through the Medical Research laboratory at The Johns Hopkins Hospital or at the University of Maryland. Also many schools have a Vocational Guidance Program. The Society will supply and often has supplied a speaker at a school's request, to talk on the opportunity for young people in various fields of medicine such as training to be a doctor, a nurse, a technician, a pharmacist or laboratory assistant and so forth. He can direct the young student how and where to get the knowledge that he needs and that the world needs. This of course is vitally important since there are always shortages in these fields which yearly are becoming more acute.

The main point to us of course is to use these wonderful aids for public medical education which the Maryland Society for Medical Research has made available to us at great expense to itself. But whatever you decide to do, organize and get in touch with us so that we can know what you are doing and help you in every way possible. Good Luck!

AUXILIARY NEWS

The new officers elected at our Annual Meeting are: President, Mrs. Charles H. Williams, Pikesville; President-elect, Mrs. John G. Ball, Bethesda; First Vice-President, Mrs. H. Hanford Hopkins, Ruxton; Second Vice President, Mrs. James T. Marsh, Westminster; Third Vice President, Mrs. S. Jack Sugar, University Park; Fourth Vice President, Mrs. George E. Urban, Catonsville; Recording Secretary, Mrs. Harry F. Klinefelter, Baltimore; Corresponding Secretary, Mrs. James G. Sasscer, Upper Marlboro; Treasurer, Mrs. Emil G. Bauersfeld, Chevy Chase; Parliamentarian, Mrs. Jack H. Beachley, Hagerstown. Chairmen will be announced as soon as possible by the President, Mrs. Charles H. Williams.

"Medicine and The Bible" a talk given by Dr. Louis Krause, Professor of Clinical Medicine, at the School of Medicine, University of Maryland, made our Annual Meeting Luncheon a great success. The luncheon was very well attended and the many doctors present seemed to appreciate thoroughly the medical references which Dr. Krause unearthed in Holy Writ along with the poetry and humor which he found.

The Creative Arts Show was even better this year. We have talent in the "family"! Mrs. Beverley C. Compton does such an outstanding job on this show that we just hope she'll keep right on doing it!

Mrs. Page C. Jett, original Treasurer of the Woman's Auxiliary to the Medical and Chirurgical Faculty did not, because of pressure of time receive the Standing Vote of Thanks which she deserved, but we all know in our hearts how much we owe to her.

The component President's reports really opened our eyes as to how much has been accomplished by the Maryland Auxiliary this year!

Those educational movies and exhibits which we saw at the Annual Meeting are interesting as well as informative. Everyone enjoyed seeing them and the Auxiliary can place them before any group with confidence that they will contribute to a successful program.

THE OLD SCHOOL TIE

Your husband owes his medical education to some fine School of Medicine. If he does not want Government control of medical education, have you reminded him to honor his Alma Mater by supporting The American Medical Education Foundation.

REMARKS FROM OUTGOING PRESIDENT'S REPORT

MRS. GEORGE H. YEAGER,
Retiring President

This year the Woman's Auxiliary to the Medical and Chirurgical Faculty has worked in support of the Medical Society on many health problems. . . . we have publicized the need for blood typing and individual identification tagging in Civil Defense

and have endeavored to place Auxiliary members as volunteers in Casualty Clearing Stations. The Auxiliary has attended hearings, testified and written letters favoring the fluoridation of drinking water in support of the position taken by the Medical Society. We are cooperating with the Maryland Society for Medical Research in a permanent educational campaign. An excellent Public

Relations factor was the Governor's Proclamation of March 30th as Doctor's Day in Maryland. We are studying, with advice from the doctors, the toll in terms of traffic accidents of drivers who may be physically or mentally impaired. Our proudest "achievement" of the year is to be working along with the doctors to help educate the public on handling health problems in the American way.

ASSISTANT PSYCHIATRIC PHYSICIAN NEEDED

The Department of State Employment and Registration is accepting applications for a pending unassembled examination for the position of Assistant Physician, Psychiatric.

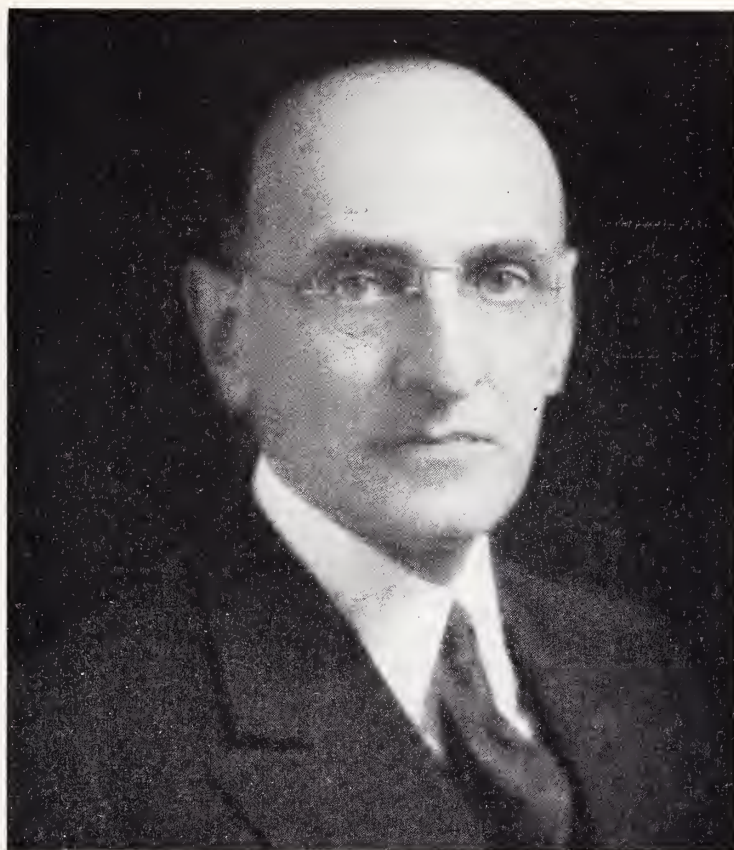
The position is under the State Merit System which includes advantages such as security of employment, liberal vacation and sick leave, automatic salary increases, and retirement benefits. It offers an opportunity to become associated with the expanding and vigorous mental health program recently initiated by the State.

Applicants must be graduates of a recognized medical school, must have completed one year's internship in an accredited hospital and must possess a valid license to practice medicine under the Maryland State Law.

The salary range is \$4,620-5,775 a year, with increases of \$231 a year for five years to the maximum of \$5,775. Maintenance is available at cost.

We will greatly appreciate any assistance you may be able to give us in referring applicants. Interested candidates should contact the State Employment Commissioner's Office, 31 Light Street, Baltimore 2, Maryland.

DR. ALFRED ULLMAN—A TRIBUTE*



Dr. Alfred Ullman who was graduated from the College of Physicians and Surgeons in Baltimore on April 29, 1902, marks his fiftieth year in the private practice of Surgery. Not long after his graduation and by virtue of diligence, study and preceptorship under Dr. John Chambers, Dr. Ullman became professor of Anatomy and Clinical Professor of Surgery at the College of Physicians and Surgeons.

It is exciting to reflect upon the era in which he was privileged to practice surgery and observe the advent of asepsis, antisepsis, as well as the remarkable progress of major surgery in which he still engages actively.

An acquaintance of such men as Doctors Halsted, Kelly, Osler and Welsh, and a friend of Dr. John M. T. Finney, Sr., Dr. Ullman lived through the most thrilling, productive and progressive era of Medicine and Surgery to become one of the peers in Surgery in the City of Baltimore and one of the eminent surgeons in this country.

He has trained many men who are now either outstanding or are on the road to prominence in

surgery in this city and abroad. His experience and profoundly good surgical judgment have been imparted to the interns and residents who have served under him.

Dr. Ullman served as Surgeon-in-Chief of the Sinai Hospital from 1928 to 1945. The part which he played in the training of many surgeons in this city cannot be measured and may not be truly appreciated for many years to come. His former residents respect and recognize his teachings and influence as being of the highest order. Today he is the same wise, experienced and vigorous surgeon who effectively left an imprint upon Sinai Hospital and other medical institutions.

Among the positions he holds and the societies to which he belongs are: Chief Consultant in Surgery at Sinai Hospital since 1946; Consultant, South Baltimore General Hospital; Fellow American College of Surgeons, Diplomate American Board of Surgery; Member, Baltimore City Medical Society; Member, American Medical Association.

This month is a milestone in his eminent career which we hope will continue for many more years.

* Contributed by Louis J. Kolodner, M.D.

MARYLAND ACADEMY OF GENERAL PRACTICE

NATHAN E. NEEDLE, M.D.*

A number of members of the Maryland Academy of General Practice and their wives attended the Fourth Scientific Assembly of the American Academy of General Practice held in Atlantic City, this spring. This meeting brought together about 2000 physicians engaged in general practice from the 48 states, District of Columbia and Hawaii. The delegates representing the Maryland Chapter were: Drs. Charles O'Donnell, Towson; E. I. Baumgartner, Oakland; George A. Knipp, Baltimore; and Harold Flummer, Preston.

Dr. E. I. Baumgartner, President, and Dr. Nathan E. Needle, of Baltimore, Secretary of the Maryland Academy, were members of the General Committee on Arrangements. Mrs. Baumgartner and Mrs. Needle were members of the Ladies Entertainment Committee in Charge of Registration. Dr. Baumgartner was a member of the Committee on Scientific Assembly.

Among the speakers who addressed the delegates on various advancements in medicine covering physiological diagnosis and treatment was Dr. John C. Krantz, Jr., Professor Pharmacology, School of Medicine, University of Maryland. Dr. Krantz' subject was "Recent Advances in Therapy."

Among other speakers were Dr. Hans Selye, Director of Institute of Experimental Medicine and Surgery at the University of Montreal; Dr. Jerome W. Conn, University of Michigan Medicine School; Dr. Selden D. Bacon, Professor of Sociology at Yale University; Dr. O. Spurgeon English, Head of the Department of Psychiatry, Temple University Medical School; Dr. Robert B. Greenblatt, Professor of Endocrinology, Medical School of Georgia; Dr.

M. Edward Davis, DeLee Professor of Obstetrics and Gynecology, School of Medicine, University of Chicago; Dr. William Dameshek, Editor of "Blood"; and Dr. Cyril MacBryde, Washington University School of Medicine.

Members of the Maryland Academy listed among the Doctor's Registrations included: Drs. T. G. Abbott, Baltimore; P. Artigiani, Baltimore; J. M. Bankhead, Silver Spring; E. I. Baumgartner, Oakland; C. F. Benson, Baltimore; J. S. Blum, Baltimore; M. N. Borden, Baltimore; W. Brainin, Capitol Heights; J. D. Bubert, Baltimore; C. P. Crimy, Baltimore; M. N. Cross, Silver Spring; L. Dalmau, Pikesville; M. B. Davis, Baltimore; B. Dorogi, Cardiff; W. L. Etienne, College Park; B. L. Grant, Shadyside; S. Goldberg, Baltimore; M. Grossfield, Baltimore; H. A. Grott, Parkville; H. V. Harbold, Baltimore; C. R. Hayman, Bel Air; W. P. Hudson, Forest Hill; E. W. Johnson, Baltimore; S. L. Johnson, Baltimore; L. L. Keown, Baltimore; B. Kader, Baltimore; B. B. Kneisley, Hagerstown; G. A. Knipp, Baltimore; K. Krulevitz, Baltimore; A. R. Lapin, Clinton; C. Rodney Layton, Centreville; G. A. Moulton, Westminster; J. R. Myerowitz, Baltimore; N. E. Needle, Baltimore; E. F. Nevy, Dundalk; C. F. O'Donnell, Towson; W. S. Parsons, Baltimore; A. Piazza, Baltimore; H. B. Plummer, Preston; L. J. Pratt, Jr., Towson; M. M. Rothstein, Frostburg; N. E. Sartoris, Jr., Pocomoke; H. W. Scheye, Baltimore; L. R. Schoolman, Frederick; W. H. Shealy, Sharpsburg; H. G. Summers, Baltimore; G. M. Smith, Barnesville; H. R. Tobias, Hancock; F. J. Townsend, Jr., Ocean City; E. M. Tracey, Jr., Ocean City; T. E. Wheeler, Randalls-town; M. L. White, Silver Spring; D. Wilansky, Perry Point; and I. M. Zimmerman, Williamsport.

* Secretary, Maryland Academy of General Practice.

MURRAY AND DINGELL INTRODUCE BILLS FOR HOSPITALIZATION-AT-AGE-65

Capitol Clinic, A. M. A., Vol. 3, No. 15, April 15, 1952

Senator Murray and Rep. Dingell have introduced identical bills to authorize establishment of a system of government-paid hospitalization for everyone eligible for social security benefits. Eligibles would include persons 65 and over who are covered by social security and their dependents as well as the survivors of deceased persons so insured. Hospital benefits would be limited to 60 days in any one calendar year.

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PROBLEMS OF PRACTICE¹

W. EDWARD GALLIE, M.D.²

Your kind words of introduction remind me of the feeling I have always had in Baltimore, that far from being a stranger in a strange land, I am among friends. Not only have I grown up with many of you in our art and science but I am ever conscious that in many surprising ways your traditions are our traditions. Indeed except for some considerations of geography and of political institutions, we are one people.

You have probably noticed that in the past few weeks a great and historical political event has occurred in Canada. Newfoundland has at last entered Confederation and has become our tenth province. This must recall to you that the founder of the first settlement on the south-east corner of Newfoundland, the peninsula of Avilon, was the same man who brought the first English settlers to Maryland and gave his name to this city. George Calvert, Lord Baltimore,

received charters for both these enterprises from King Charles the First, early in the 17th century, over three hundred years ago.

But of far greater interest to me is the recollection of the contacts I had with some of the men who have made Maryland and American Medicine great. I met Sir William Osler only once, on the occasion when he delivered his famous address to the medical students in Toronto on the "Master Word in Medicine." But my contacts with him go far beyond that for it happens that I was born in Barrie, Ontario, and received my education in the Barrie Grammar School where Osler had gone to school thirty years before. I actually knew several men who were schoolboys with him at that time and took part in the pranks that have been so well described by Harvey Cushing. The Osler tradition there is very strong.

Sixty years ago to-night Professor Osler was the guest speaker of the Medical and Chirurgical Faculty of Maryland. His subject was "Licence to Practice." In his address he attacked the existing system of Medical education and the

¹ I. Ridgeway Trimble Lectureship presented at the Sesquicentennial Celebration of the Medical and Chirurgical Faculty, Lyric Theater, Baltimore, Maryland, Monday, April 25, 1949.

² Dean, Faculty of Medicine, University of Toronto, Toronto, Canada.

absence of safeguards for the protection of the public from quacks, charlatans and shockingly untrained doctors. He asked "Is it to be wondered, considering this shocking laxity that there is a widespread distrust in the public of professional education?"

Reading this address of sixty years ago has set me thinking of what has happened in medical practice in the intervening years and where we stand to-day in our relationship with the public. At this point one is tempted, particularly in the presence of an audience composed largely of other than the medical profession, to review the glorious record of achievement of the last half century. Even in my own time the forward march of the basic medical sciences and of medicine, surgery, and all the specialties has been almost unbelievable. This era of glorious advancement which has seen the establishment of our mastery over typhoid fever, diphtheria, pernicious anaemia and diabetes; over surgical infections and the hidden diseases of the abdomen, the thorax and the brain, has occurred in the stimulating atmosphere of free enterprise and has been brought about by the unfettered enthusiasm of crowds of young people like Osler and Cushing here and like Banting and Best in my own country.

And as I think of this glorious era I cannot help wondering if it could have happened under state medicine. Would the fires of research have glowed as brilliantly under bureaucrat direction and political control as they have in the immediate past? Could management by the civil service have been as successful in attracting these bright young minds to the study and solution of the problems of health and disease? My experience with politics and the civil service makes me doubt it and makes me think that we should avoid at all cost the introduction of socialistic changes which could so easily kill the goose that laid the golden egg.

This craze for socialized medicine is part and parcel of the general demand for social security. It is not a criticism of the quality of the service

we are giving, but rather of the cost of it. And when one considers the colossal bills that follow an ordinary illness such as pneumonia or appendicitis, one cannot help sympathizing with the low income citizen when he looks about to see if he cannot get somebody else to pay for it.

The remedy is not too clear at the present time but in my opinion it should centre on this problem of cost. Some scheme must be discovered which will lessen the load of the ten to twenty dollars a day charge of the hospital and the ten to twenty dollars cost of the nurses.

But in searching for means of reducing the cost of illness what folly it would be to destroy the goodwill of the doctors and to make them sorry they had ever come into the profession. The spectacle of what is going on in England and New Zealand with their schemes of state medicine, is quite enough to drive bright and clever young men into other fields of endeavour. At any rate there will be no sons of doctors entering medical school if state medicine comes. I would venture to predict that with the advent of socialized medicine, as it is advocated by the socialist and communist parties, this golden age of medical discovery will come to a close and we shall enter a period when progress in the study of health and disease will bog down to the speed of the civil service. The idea that medical research can be kept alive by government grants is just silly if it turns out, as I think it will, that the bright boys no longer want to be doctors and will no longer enter the schools.

The appalling cost of illness is largely due to the rise of hospital rates and to the cost of nursing care. Fifty years ago when we took sick we went to bed at home and the doctor came to see us there. To be sent to hospital seemed like a death sentence. Now, however, largely due to our advocacy of the virtues of hospitals and to the development of the "Blue Cross" and other insurance plans, everybody wants to go to the hospital on the least provocation. The result is an outburst of hospital building at such fabulous prices that the daily rates can do nothing but

rise. How we are ever going to get nurses enough to staff these new hospitals is beyond me, for I am convinced that with the rising demand of industry, of public health, of aeroplanes and of the public and high schools, for trained nurses, the chances of getting nurses enough to take care of the sick are steadily growing less. Indeed, I feel sure that the day of a plethora of nurses is over and that it is time we were thinking of how we can do without them.

First, let us consider the hospitals. Do we really need the enormous increase of hospital beds that is now being demanded? How many are being occupied by patients who have been sent in for complete laboratory investigation and for observation and who really do not need to sleep in the hospital at all? It seems to me that a great many are in this class. Would it not be preferable, instead of building hospitals, to build clinics where a patient could undergo a complete investigation and then return to his own home? This would speed up the programme, reduce the need for nurses and cut down the expense. It is certainly worth thinking about before calling in the architects.

The problem of the nurses is occupying the attention of hospital administrators and the nursing schools all over the world. The other day I saw a big sign in the Strand in London, England, announcing that the governments of Australia, New Zealand, and South Africa would welcome applications from young British girls to go out to those Dominions at government expense and on specified salaries to train in hospitals as nurses. The shortage, indeed, is universal.

The reasons given are varied but they all seem to boil down to the fact that to many, nursing the sick has lost its charm. In earlier days a high proportion of the girls entered training schools in the spirit of Saint Anne, gladly devoting their lives to the service of the sick and accepting as their reward the gratitude of their patients and the hope of happiness hereafter. Gradually, however nursing has changed to a profession, an ill paid one at that, and one that requires high

standards of preliminary education and years of special training. In the presence of ever increasing opportunities for young women in business, in pedagogy and in countless other fields, with limited hours of work, week ends off and higher pay, it is no wonder that volunteers are lacking. What the solution is I do not know but I suspect that it lies along the way of learning to get along with fewer trained nurses, who will occupy the posts of greater responsibility with pay and living conditions such as to attract bright young women, and filling in the vacancies with a lower grade of personnel. However, this is a problem not for the doctors but rather for the hospital administrators and particularly for the nurses themselves. No solution will be satisfactory that does not come from them and carry their staunch support. My only purpose in mentioning it at all is to emphasize what many of us think, that the shortage of nurses is permanent and urgently calls for thought.

Returning to a consideration of the changes in medical education and in practice since Osler delivered this lecture sixty years ago one cannot fail to be impressed with the enormous progress that has been made. What the great physician advocated that night, namely a reformation in clinical teaching and the setting up of high standards for hospitals and medical schools and for licensure to practice, have all been brought about, and, mark you, have been brought about by the doctors themselves. The idea that this kind of reform could have been brought about by any government bureaucracy is the sheerest nonsense.

These sixty years have seen the rise of the internist, the surgeon, and the various kinds of specialists. It is but natural that with the enormous broadening of the field of medicine, practitioners have been forced to concentrate on narrowing portions of that field in order to maintain a standard of excellence. There are many of us, however, who feel that this swing to specialism has gone far enough and that a little more attention should be paid to the general practi-

tioner. Indeed, for some reason or another, the public seems to have lost a great deal of its former respect for the old style family doctor, and rushes off at once to whatever specialist seems to be most suitable to their particular complaints. It is amazing how often nowadays patients come in who state they have no family doctor and who are quite surprised when I decline to see them except at a doctor's request.

This is most unfortunate for I am convinced it often leads to poorer instead of better service. The ideal family doctor is competent to diagnose all but the most uncommon ailments and he is familiar with the treatment required. If he really is the family doctor he is also a trusted friend who can be depended upon to call the proper consultant if another opinion is needed and to select the most suitable specialist if special treatment is required. Above all, he knows his patients far better than any chance consultant ever can and being their trusted counsellor and friend he has their interests close to his heart. When I get sick I want my old family doctor; none of your specialists for me.

But just as Sir William advocated an increase of the medical course from two to four years, with emphasis on basic sciences and clinical study at the bedside so I have to recommend, sixty years later, another extension of the programme of training. It seems to me that with all the advances that have been made in medicine, pediatrics, obstetrics and minor surgery it is impossible for a student, no matter how diligent he may be to get a practical grip of his subject in four undergraduate years. Almost all this time he has had his nose on the grindstone with lectures, clinics and laboratories and is awake at all hours of the night preparing for examinations. At no time is he given responsibility for sick patients or given the opportunity actually to be the doctor. The result is that while at graduation he has had a better basic and theoretical training than ever given before, yet he has not had sufficient apprenticeship to fit him for actual practice.

To get over this defect in his education he needs a general rotating internship. This I believe should be compulsory and required by the laws of the state or province, for licensure. This is actually the law in some places but it is by no means universal. Some of the leading hospitals associated with medical schools do not have a rotating internship at all. It seems to me that an adequate preparation for general practice requires an internship which includes six months medicine, six months obstetrics and pediatrics and six months minor and emergency surgery, including fractures. If to this were added six months or a year of training with a busy practitioner the course would be complete. Such a plan, of course, would require that hospitals paid the interns a sufficient honorarium to make them independent.

But while making an adequate internship compulsory for licensure would be a great advance, it would fall far short of the ideal unless the medical school takes a much more active interest in the welfare of the intern than it has done in the past. It is notorious that in many hospitals the interns are simply servants who carry out routine work without any pedagogic supervision or spiritual stimulus whatsoever. Everybody must have observed how frequently the lean, alert, anxious medical student degenerates during his first six months as an intern. This comes from the too sudden release of the graduate from the discipline and supervision of school. What is needed is a more gradual transition from the rigours of medical school to the independence of practice. It calls indeed for a continuation of the curriculum of the school into the intern years, with sufficient clinics, discussion classes and practice demonstrations to make sure that the intern is getting the best out of his service. What I am suggesting, indeed, is that we cease to look on interns as servants of the hospital but rather regard them as post-graduate students whose quality as practitioners of medicine will depend largely on our skill as teachers. I am suggesting that we make it im-

possible for the intern to complete his training without having done, and accepted responsibility for all the things he must do in practice.

Of the rise of the specialist since sixty years ago, so much has been said that I need only touch on it. Indeed I know very little about it except as it applies to the surgeon. These sixty years, however, have seen an extraordinary change in his education and in his practice. At the beginning he was a general practitioner who had a special interest in operative work and had ultimately become proficient in some of the common procedures. Gradually, however the field became wider including the hitherto unexplored fields of the abdomen, the chest, the nervous system and the bones and joints, so that it became necessary for the budding surgeon to spend years in training before setting up in practice. To protect the public in this period of change the American College of Surgeons and the American Boards of Surgery in the United States, and the Royal College of Physicians and Surgeons in Canada have been set up to establish the standards of training that are necessary to efficient service. As yet these standards have not been made obligatory but the time is not far distant when they should be. Just as Osler pointed out the necessity for obligatory standards for the general practice of medicine I now urge that consideration be given to the limitation of major surgical practice to those who have been properly trained for it. The notion that a degree from a medical school and a license to practice granted by a State or provincial board is sufficient qualification for a man to engage in any kind of practice is nonsense and should be corrected as soon as possible. While it is obvious that to bring in restrictive legislation too suddenly would cause hardship and arouse so much resentment and resistance that the needed reform would be retarded yet I feel sure that if the problem is handled wisely both the public and the profession will agree to proposals that guarantee that the practitioners to whom are entrusted the lives and limbs of our patients

have been adequately trained. Just as there are now minimum standards set for licensure for general practice so there should be minimum standards, such as those required by the Boards, for license to practice a specialty.

In these times when various forms of socialism are sweeping over the world it is particularly important that we should retain the confidence of the people. We have been and still are looked upon as an honourable profession, doing our daily work because we like to do it and concerned more with the service we give and the satisfaction we get out of it than with its pecuniary rewards. It is very essential, just now, however, when people are resenting the rising cost of medical care that we do not occupy a prominent place in the general clamor for higher pay. I really believe that the most useful service we could give to the public as well as ourselves would be to do everything possible to reduce those rising costs. The lavish use of expensive drugs, the multiplications of x-rays and the free use of physiotherapy make the bill that the patient must pay on leaving the hospital truly astronomical. Over and over again I have heard of low income people such as university professors who literally had to mortgage the house to pay for an illness. Now while the doctor's bill is a mere fraction of this cost, yet the patient is inclined to blame the doctor for it and to a certain extent he is right.

The other day a friend of mine, a professor of mineralogy, consulted his physician about some discomfort in the upper part of his abdomen. After taking the history the doctor decided that hospitalization was necessary in order that a complete investigation could be carried out. The patient entered hospital on a Friday night but by that time the physician had gone out of town for the week end and did not get back till Monday afternoon. He then ordered a gastrointestinal series, a gall-bladder series, chest and spinal x-rays, an electrocardiogram and the whole list of blood and urine analyses with particular emphasis on liver function tests. He wanted to

make sure that nothing was overlooked. So all his investigation was completed and one by one the tests were reported negative. In the meantime the patient had completely recovered from his indigestion. He left his ward with a spring in his step and the light hearted feeling of one who has had a narrow escape from catastrophe. This lasted till he reached the wicket where he received his hospital bill. Then all the symptoms returned with threefold intensity. The fact that the doctor, being a fellow member of the faculty and a personal friend, didn't send him a bill, didn't seem to help.

I suggest, therefore, that we do not send anyone into a hospital not urgently needing to go, that we pause a moment before ordering a list of expensive clinical investigations that have no direct bearing on the case, and that we reserve the use of antibiotics and whole blood to patients who really need them.

It is particularly important in these changing political times that we do not leave ourselves open to the charge of commercialism. Of course we want to make a decent living and to have incomes that will enable us to live in social equality with those of a similar cultural status as our own. But we should also have the credit for the perfectly enormous amount of service that we render without any charge whatever and without a hope of financial reward. The public can hardly be made to believe that the staff appointments to our in-patient and out-patient services carry no salaries or honoraria. But much more spectacular than the day by day free contribution of the doctor to the general public welfare are the wonderful gifts to humanity that have been made by medical research.

The one that I know best is that in relation to diabetes, for once upon a time Sir Frederick Banting was my house surgeon and Charles Best was my student. When one realizes that there are nearly a million diabetics in the United States and Canada who are being kept alive and in good health by insulin, what a killing those two boys could have made if they had capitalized

on their discovery. If for instance they had sold their process to the manufacturers with a royalty of one cent a day from each patient, that would have amounted to \$3,000,000.00 a year. And that they did not do this was no mischance for I can assure you that I listened one night twenty-five years ago to a full discussion of the subject by the insulin committee of the University of Toronto, where with a complete realization that the discovery was a success and that the income that could be derived from it would be enormous, the discoverers in cold blood decided to live up to the traditions of our profession and to hand over their discovery to the world. This is something that is understood neither by capitalists nor communists but it is one of the glories of our profession that make us resent the suggestion that in the future we are to be pushed around by bureaucrats and civil servants. It is my firm conviction that if thirty years ago medicine had been socialized on one of the plans now being threatened, Frederick Banting and Charles Best would never have registered in a medical school and the diabetics would have been dying of coma as usual.

It is my pleasant duty to bring to you the greetings of the Canadian and Ontario Medical Associations. Just as you represent the doctors of Maryland and of the other United States, so our Canadian Associations speak with authority for the medical profession in Canada. Our association with you in times of peace, over the last hundred and twenty years, and in times of war, in the last thirty years, has done nothing but raise our admiration for you. The kindly way in which the Canadian doctor is received in the United States never fails to astonish us and to arouse our deep appreciation.

In these anxious times when there hangs over us the threat of atomic war and we figuratively scan the northern skies in search of enemy aircraft it may be comforting to you to know that here and there along the shores of the Arctic Ocean and of Hudson's Bay are increasing groups of Canadian airmen and radar experts.

This was brought home to me most forcibly when a well known surgical colleague, one of the senior medical officers of the Royal Canadian Air Force flew to Baffin Land to inspect the medical arrangements in that far Arctic post. It is just unbelievable.

One thing we Canadians are terribly keen about is that the proposed St. Lawrence waterways scheme may be proceeded with soon. By building canals to bypass the 75 miles of rapids in that great river we can open it to ocean navigation for an increased thousand miles and convert the ports of Cleveland, Toronto, Detroit, Chicago, Fort William and Duluth into ocean ports. Just as the completion of the Panama Canal made commerce originating in one ocean available to the other, so the St. Lawrence waterways will extend that commerce from the outside rim to the very centre. Strategically, too, its importance is enormous. While I know that New York, Boston, Philadelphia and perhaps Baltimore are not very keen about seeing some of their shipping proceeding up the St. Lawrence, yet in time of serious war, the more we are spread out and the less vulnerable we are to atomic bombs the better.

Just to guard against a possible feeling of disappointment among the more scientifically minded of my audience that I have said very little about practical surgery, I shall dwell lightly on a curious cult that has developed recently among the surgeons. From time to time I have held forth against the indiscriminate introduction of foreign bodies into the delicate human organism and have pointed out the evils that may result from this unscientific practice. Now, however, I would draw attention to a growing habit of dealing with certain injuries and diseases by cutting off the offending part and throwing it away. It would suggest that our faith in a Divine Providence has become so undermined that we have begun to look critically on what we have always been taught is the noblest work of God. The suggestion is that perhaps, after all, the hand of the potter does shake. The other

day there came under my care a great professional hockey player who had fractured his patella. All my young colleagues told me that the newest and best treatment would be to remove the patella; simple, free from danger and effective. Now, of course, I knew all this and have seen results that would be quite good enough for the knees of those young doctors, but I had to remember that my patient was a great centre player and that one reason he was sent to me was that I also had been a hockey player and knew something about the kind of knees that centre players must have if they are to continue to play that great game. So I stuck to the old accepted plan of trying to restore the poor boy to the mould in which God made him.

The speed with which the "cut off and throw away" cult has developed is amazing. It used to be limited to feet and fingers and hands but now it includes patellas, olecranon, clavicles, gall bladders, caecums, colons, stomachs and lungs and when the technique for each of these has been perfected we are calmly told that no ill effect from the loss of the part can be detected. The climax, as far as I am concerned, came not long ago when the neurosurgeon brought in a patient from whom he said he had removed one cerebral hemisphere. And sure enough, there was the hemisphere in a bottle. I asked the man how he felt about it and the mumbled reply didn't impress me. The surgeon assured me, however, that the patient had always talked like that and that the loss of half his brain had seemed to have no ill effect whatever.

Well I must not go too far in this discussion for fear I leave a wrong impression. I think it is well worth while, however, for the surgeon to pause when he feels the urge to cut off something coming over him, and consider that while it is interesting and often very important to know that man can get along without some of his parts, yet in the millions of years in which the process of evolution has been going on the chances are these parts have gotten used to one another and might not play the game quite so

well if some of them were missing. It might be well if these enthusiastic surgeons, before trying out these new fangled stunts on their patients, did as Banting and Best did when, before giving the new drug "insulin" to their patients, they tried it out on themselves.

The association of our tenth province, Newfoundland, with Maryland reminds me that the other day in London certain sentimental people gathered about the great equestrian statue in Whitehall to mourn the passing of the king who sent Lord Baltimore to America. It is a bright commentary on the character of the English people that there are some who every year, on January 30th, stand about this statue and drink a toast to the rightful king (over the water). The Lord only knows who the descendant of the

Stuarts really is. Certainly the Jacobites do not. And while the toast is being drunk another crowd looks on with an amused yet sympathetic smile and then all move off together as loyal subjects of King George the Sixth. A great and interesting people, but to us on this side of the Atlantic, sometimes hard to understand. King Charles the First was not a wise king and he certainly was a most unlucky one but in his magnificent exhibition on the scaffold of Whitehall he made a glorious atonement. So when January 30th comes around, you in Maryland, so named in honour of his queen, who could not possibly drink to a king named George, may raise a glass with me, a descendant of Scottish Jacobites, to Charles Stuart, the founder of your country and to Mary his queen.

THE PROBLEM OF JAUNDICE IN GENERAL SURGERY¹

HOWARD K. GRAY, M.D.²

A surgeon, when presented with a case of jaundice, wishes to know one thing: Is this a type of jaundice which can be relieved by surgical means? To make this decision, he must determine whether the jaundice is hemolytic, hepatocellular or obstructive in origin. In making the diagnosis the value of a complete and careful history and physical examination cannot be overemphasized, but also of great aid, and often the only means of confirming the diagnosis of the type of jaundice, are the laboratory tests of liver function.

Surgeons many times are prone to disregard the advantages of liver function tests which are available to them for aid in the diagnosis of jaundice. This disregard stems in general from two causes: first, the surgeon may have encountered cases in which the liver function tests were

inconclusive or misleading in their results, and second, but perhaps the more important, he does not have faith in the tests because he does not understand clearly the principles involved nor the real purposes for which each test was developed. It is a common experience that one tends to be suspicious of something about which one is unfamiliar. Because of these reactions, this paper will attempt to describe simply and clearly, some of the more commonly used tests of liver function as aids in diagnosis. There have been developed many minor variations in the technic of performing these tests, and the details of their interpretations vary from laboratory to laboratory; these variations of thought and technic are beyond the scope and intent of this paper.

To our knowledge, there is no laboratory procedure which will test all the functions of the liver at one time. It is easy to see why this is so when one realizes that the liver is probably the most important single organ in maintaining the various factors of homeostasis within the body.

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TABLE 1
Results of laboratory tests in various types of jaundice

PROCEDURE OR FEATURES	NORMAL	JAUNDICE, TYPE			
		HEPATOGENOUS	OBSTRUCTIVE		HEMOLYTIC
			Stone	Carcinoma	
Degree of jaundice	None	Variable	Variable	Deep and persistent	Variable
Evidence of hepatic functional disturbance	None	Early	Later and progressive	Later and progressive	None
Icterus index	4-6 units	Elevated	Elevated	Elevated	Elevated
Serum bilirubin (van den Bergh)	Negative direct; 0.6 mg. per 100 cc. indirect	Increased direct and indirect reaction	Increased direct reaction	Markedly increased direct reaction	Increased indirect reaction
Urobilinogen	Present in stool and urine	Present in stool and urine	Present or decreased in stool and urine	Absent in stool and urine	Present in stool and urine
Duodenal drainage, bile	Present	Present	Present or decreased	Absent	Present

PROCEDURE OR FEATURES	NORMAL	JAUNDICE, TYPE		
		Hepatogenous	Obstructive*	Hemolytic
Glucose tolerance	Normal curve	Increased response	Normal curve	Normal curve
Galactose tolerance	3 gm. or less in 5 hr.	Reduced tolerance, 3 gm. or more	Normal (early)	Normal
Albumin-globulin ratio	1.5:1 to 2.5:1	Reduced or inverted	Normal (early)	Normal
Takat-Ara	Negative	Positive	Negative	Negative
Cephalin-cholesterol flocculation	No Flocculation	Increased, grade 3 to 4	Normal (increased late)	Normal
Colloidal gold precipitation	Negative	Paretic type of curve	Negative	Negative
Thymol turbidity	0-4 units	Positive	Normal	Normal
Zinc sulfate turbidity	6-16 units	Positive	Normal	Normal
Prothrombin time	18-20 sec.	Prolonged; poor response to vitamin K	Prolonged; good response to vitamin K	Normal
Cholesterol, total	150-250 mg. per 100 cc.	Normal or decreased	Increased	Normal
Cholesterol esters	110-145 mg. per 100 cc.	Reduced	Increased	Normal
Dye of retention	None	Increased	Increased	None
Hippuric acid secretion	3 gm. or more in 4 hr.	Reduced, 2 gm. or less	Normal (early)	Normal
Serum alkaline phosphatase	4 units or less per 100 cc.	Moderately elevated	Increased	Normal
Serum amylase	Less than 320 units	Normal	Increased	Normal
Serum lipase	Less than 0.3 cc.	Normal	Increased	Normal

* Same results for obstructive jaundice due to stone and for that due to carcinoma.

It accomplishes this not only by its influence on the metabolism of carbohydrates, lipids, proteins, vitamins and bile, but also through many other functions too numerous and nebulous to mention. Because of this great diversity of ac-

tivity, a liver function test is designed to test only one specific function of the liver, and its interpretation is of this specific activity and secondarily of its relationship to the other functions of the liver.

Any condition of the liver which will produce pathologic changes in one function of the liver will ultimately cause enough damage to the parenchyma of the liver to produce changes in other functions. The average length of time for this secondary damage to become manifest is from two to four weeks. Hence liver function tests are of greatest aid in the diagnosis of jaundice during the initial two weeks of the disease. After this time has elapsed, all the tests tend to give positive results to a varying degree, and hence the specificity of the various tests is lost as is their diagnostic value. For this reason, liver function tests for the diagnosis of jaundice should be performed as early in the course of the disease as possible.

A summary of the results of the different laboratory tests in various types of jaundice is given in table 1.

TESTS OF BILE EXCRETION

Perhaps the most frequently performed tests of liver function are those which determine the ability of the liver to excrete bile pigments which, when they are present in excess in the blood, produce clinical manifestation of jaundice. Tests of this function of the liver are the icterus index, determinations of serum bilirubin (van den Bergh), determination of fecal and urinary urobilinogen, and duodenal drainage.

Icterus Index.—The icterus index is a colorimetric test in which the color of the fasting xanthophyll-free and carotin-free serum which contains no hemolyzed erythrocytes is compared with a standard potassium dichromate solution. The results of the test are not directly proportional to the amount of bile present in the serum since the bilirubin present in crystalloid form gives a deeper color than does colloidal bilirubin; hence the results do not always agree with those of the van den Bergh test. The results are reported in units, each of which is roughly equivalent to 0.05 mg. of bilirubin per 100 cc. of serum. The normal icterus index is 4 to 6 units, but it may increase to 15 units before gross evidence of clinical jaundice appears. This test is a non-

specific test for jaundice, and it is increased in any condition which produces jaundice. Its main use is in following the variations in the degree of jaundice in a patient, since it is an easy simple test.

Quantitative Determination of Serum Bilirubin (Van den Bergh Test).—The quantitative serum bilirubin (van den Bergh) test is a colorimetric procedure which is much more specific than the icterus index. It is perhaps the most frequently used test in the diagnosis of jaundice. The bile present in the serum reacts with Ehrlich's diazo reagent (diazotized sulfanilic acid) to produce a reddish color. The time that it takes the color to develop and the depth of the color determine the type of the reaction and the amount of serum bilirubin. If the color develops within sixty seconds, the result is known as a "direct reaction." This indicates that the bilirubin is in a more soluble form as a result of having passed through, and having been excreted by, the liver cells. If the color develops in from sixty seconds to several hours, it is known as a "delayed reaction." In the second phase of this test, a solution of 50 per cent methyl alcohol is mixed with the serum and Ehrlich's reagent is added. This frees the protein-bound bilirubin which has not passed through the liver cells so it can react with Ehrlich's reagent to produce the reddish color. This is known as the "indirect reaction." Normal persons usually give a negative direct reaction for serum bilirubin, and an indirect reaction for serum bilirubin up to values of 0.6 mg. per 100 cc. In the obstructive type of jaundice it is mainly the direct-reacting bilirubin which is present, but if the obstruction persists, there will soon be varying degrees of damage to the liver cells so that there will also be an increase in the indirect-reacting serum bilirubin. The bilirubin in hemolytic jaundice produces an entirely indirect reaction, as it has not passed through the liver cells. In hepatocellular jaundice the bilirubin in the early stages is mainly indirect reacting, but as the disease progresses, it becomes both direct and indirect reacting.

Test for Urobilinogen.—Urobilinogen is formed

in the intestine by the action of the intestinal bacteria on bilirubin. The majority of the urobilinogen is excreted in the feces as urobilin, stercobilin and mesobiliviolin. A small portion of the urobilinogen is resorbed into the portal circulation from the intestine and it passes back to the liver where most of it is again excreted into the intestine (enterohepatic circulation). However, a small portion of it passes into the general circulation from which it is excreted by the kidney in the urine.

The test for urobilinogen, whether in the urine or the feces, again depends on the reddish color produced by bilirubin or its derivatives and Ehrlich's reagent (paradimethylaminobenzaldehyde). This color is compared with that of a standard solution. The urobilinogen in the feces is reported as milligrams per 100 gm. of stool or milligrams excreted per twenty-four hours. The normal amounts are 150 to 300 mg. per 100 gm. of feces or a daily output of 40 to 300 mg. of urobilinogen. The amount is decreased or absent in obstructive jaundice and it tends to be much lower, if not entirely absent, in obstructive jaundice due to neoplasm than in that due to stone. The amount of fecal urobilinogen is increased in hemolytic jaundice.

In the urine, the normal amount of urobilinogen is 4 mg. or less per twenty-four hours. It is absent in case of complete biliary obstruction, and it is increased in case of hepatocellular damage or hemolytic jaundice.

Duodenal Drainage.—Duodenal drainage is a valuable procedure. A Levine type of tube is passed so that the tip will rest in the duodenum. Fifty cubic centimeters of a 25 per cent solution of magnesium sulfate is instilled through the tube. Normally, the first bile is clear and thin as it comes from the common duct. This is followed by a much thicker and darker bile which apparently is from the gallbladder. The last bile to be obtained is again clear and thin and is considered to be that which has just been excreted by the liver. The bile, if obtained, indicates at least some degree of patency of the bile ducts, but it may be minimal in amount in cases of severe

hepatocellular damage. The presence of cholesterol and calcium bilirubinate crystals is indicative of stones in the biliary system, and blood is indicative of tumor although it may result from trauma. Pus cells are found in cases of cholangitis, and the recognition of malignant cells in bile may be of practical value at some future time.

TESTS OF CARBOHYDRATE METABOLISM

Glucose Tolerance Test.—The glucose in the blood is maintained, in part, at near constant levels by the liver which converts glucose to glycogen, in which form it stores carbohydrates until the extrahepatic stores of glucose are decreased. Glycogen is then reconverted to glucose and is released into the general circulation.

The glucose content of the blood is determined by heating protein-free blood filtrate with an alkaline copper solution. The glucose reduces a portion of the copper to cuprous oxide which in turn reduces phosphomolybdic acid to phosphomolybdous acid which is blue in color. This color is compared with a standard, and the amount of glucose reported in milligrams per 100 cc. The glucose tolerance test is performed, after determining the fasting level of glucose in the blood, by giving the subject orally an amount of glucose calculated on the basis of body weight. The levels of glucose in the blood and urine are then determined at intervals of thirty minutes, one, two and three hours.

When there is damage to the liver cells, wide variations are noted in the levels of glucose in the blood in response to the glucose tolerance test. Following the administration of glucose, the level of this substance rises rapidly in the blood, but the curve differs from that of the diabetic in that it falls more quickly to fasting levels. The fasting level in the nondiabetic patient with hepatocellular disease is reached in two to three hours. The results of the glucose tolerance test may be indicative of hepatocellular disease, but owing to its nonspecific nature, it is not often used for the diagnosis of this type of jaundice.

Galactose Tolerance Test.—Much more specific

for the diagnosis of jaundice is the galactose tolerance test. Galactose is a carbohydrate which is converted to glycogen entirely by the liver and it is not metabolized as galactose by the extra-hepatic metabolic processes of the body. The test is commonly done by giving the fasting patient 40 gm. of galactose in 400 cc. of water by mouth. The amount of galactose excreted in the urine, that is, not metabolized by the liver, is measured over a five-hour period. More delicate is the intravenous galactose tolerance test wherein 1 cc. of a 40 per cent solution of galactose is given per kilogram of body weight. The quantity of galactose in the blood is determined after seventy-five minutes.

With the use of the oral-urinary method of determining galactose tolerance, the normal person excretes 3 gm. or less of this sugar in five hours. In the hepatocellular type of jaundice, 4 or 5 gm. are excreted. In an obstructive type of jaundice, 40 to 50 per cent of the patients will give positive results with the galactose tolerance test, which means that quantities in excess of 3 gm. are excreted in a five-hour period. In general the test is not a definite diagnostic test, but the results may corroborate other evidence to help make the diagnosis. The intravenous test is much more sensitive. It has been reported that when more than 20 mg. of galactose per 100 cc. remained in the blood after seventy-five minutes, the results of the test were positive in 97 per cent of the cases of cirrhosis, in 81 per cent of the cases of hepatitis, and in 18 per cent of the cases of obstructive jaundice of less than six months' duration.

TESTS OF PROTEIN METABOLISM

In the synthesis of body proteins, the liver serves as an important link. The amount of total serum proteins reflects this function in that it is moderately decreased in chronic hepatocellular disease. However, the amount of total serum proteins is affected by many conditions other than disease of the liver, and hence it is of no great diagnostic significance.

Albumin-Globulin Ratio.—Of more importance in the diagnosis of jaundice is the albumin-globulin ratio and the changes which occur in the globulin fraction of the serum proteins. In primary hepatocellular disease there is a decrease in the albumin fraction and an increase in the globulin fraction of the serum proteins, thus producing a lowering or inversion of the normal albumin-globulin ratio of 1.5:1 to 0.5:1.

Tests for Abnormal Serum Globulin.—When damage to the parenchyma of the liver has occurred, more specific changes are seen in the gamma globulin fraction of the serum proteins than in the albumin fraction. These changes are not due primarily to changes in the liver but they seem to be the result of reticulo-endothelial irritation. Hepatitis can produce these changes but other conditions producing reticulo-endothelial irritation such as subacute bacterial endocarditis, rheumatoid arthritis, infectious mononucleosis, and tuberculosis can also produce the same changes in the serum globulin and hence also give the same reactions. However, it is usually not necessary to consider these diseases when one is trying to classify a type of jaundice. Tests which utilize changes in the globulin fraction of the serum proteins are the Takata-Ara test, cephalin-cholesterol flocculation test, colloidal gold flocculation test, and the thymol turbidity test.

Takata-Ara Test.—The oldest of this group is the Takata-Ara test. In this test mercuric chloride and sodium carbonate react with the abnormal globulin in blood to precipitate mercuric oxide. In general, the test is difficult to perform and difficult to interpret. Positive reactions are obtained in late cirrhosis and other forms of hepatocellular disease. Negative reactions are found in obstructive jaundice and metastatic malignant disease of the liver. Because this test is not highly sensitive in relation to hepatic function and because a large variety of conditions not related to disease of the liver give positive reactions, it is little used today.

Cephalin-Cholesterol Flocculation Test.—This

test is a useful one introduced by Hanger in 1939. It depends on the production of a precipitate (flocculation) of a prepared cephalin-cholesterol mixture by the abnormal globulin of the patient's serum. The reaction, as in other flocculation tests, depends on the presence of excessive amounts of gamma globulin and a decrease in the albumin or fraction of the albumin which inhibits the flocculation. The test is read after forty-eight hours and is reported on the basis of grades 1 to 4, depending on the degree of flocculation. Grade 3 and grade 4 reactions are considered significantly positive. The test is of great aid in the diagnosis of infectious hepatitis as the result is almost always strongly positive even in the early stages of the disease. The result is also positive in a high percentage of cases of cirrhosis or advanced metastatic involvement of the liver with cancer. It is usually negative in obstructive jaundice until the obstruction produces secondary changes in the liver.

Colloidal Gold Precipitation Test.—The colloidal gold precipitation test of Lange on spinal fluid has been modified for use with blood serum. That test depends on the precipitation of the colloidal gold by the abnormal globulin in the serum with the resulting decolorization of the solution. Complete decolorization of the solution is indicated by the figure "5." Varying dilutions of serum are used, and a positive reaction produces a curve similar to the paretic curve of the spinal fluid (5555542100). Like other flocculation reactions it is positive in hepatocellular disease.

Thymol Turbidity Test.—The thymol turbidity test was introduced by Maclagan in 1944. It has proved to be extremely useful because it is easy to perform and because it is one of the most reliable tests in the differentiation of obstructive jaundice from hepatocellular jaundice. A positive reaction depends on the abnormal globulin of the blood, producing flocculation of a saturated thymol solution of pH 7.8 which contains a barbitone buffer. The turbidity of the solution is compared with Kingsbury turbidity standards, and the results are reported in units of turbidity.

The normal turbidity is from 0 to 4 units. Positive reactions early in the course of jaundice indicate hepatocellular damage, and negative reactions in early jaundice indicate that obstruction is the cause. In general, it has been shown that the thymol turbidity tests gives more uniformly negative results in the obstructive type of jaundice while the cephalin-cholesterol flocculation test is more likely to give positive results in hepatocellular disease.

Zinc Sulfate Turbidity (Kunkel Test).—The zinc sulfate turbidity test for abnormal amounts of gamma globulin in the serum proteins was devised by Kunkel in 1947 after he noted that salts of heavy metals in proper concentrations and at a proper pH would cause a precipitation of these globulins. The test is performed by mixing one volume of serum to be tested with sixty volumes of zinc sulfate reagent (ZnSO_4 , barbiturate buffer at pH 7.5) and allowing these to stand for thirty minutes. After this time the amount of flocculation is determined by a spectrophotometer at 650 m μ and reading is then converted to units by means of a calculation chart. The normal is 6–16 units and elevated readings in disease can occur as high as 50–60 units.

The advantages of this test are that a single known alteration in the serum is measured, that is, elevation in amounts of gamma globulin, and the test is simple to perform, the reagents are stable, and the results are easily reproducible.

The results are elevated markedly in infectious hepatitis and hepatic cirrhosis and are generally normal in obstructive jaundice and in cholecystitis. High values may also be found in certain conditions associated with increased antibody production, but these do not reduce its value in the differential diagnosis of jaundice.

Prothrombin Time.—Prothrombin is a carbohydrate-containing protein produced exclusively by the liver when adequate amounts of vitamin K are present. Vitamin K is a fat-soluble vitamin which is absorbed from the intestine in significant amounts only when bile is present. Hence prothrombin may be deficient either when there

is severe hepatocellular damage or when there is obstruction to the bile passages.

The amount of prothrombin in the blood is measured indirectly by its ability to produce a clot in a definite period of time. Standard conditions are set up using the patient's plasma, an excess of calcium and a prepared solution of thromboplastin. The time that it takes the mixture to produce a clot is known as the prothrombin time, and it is very roughly inversely proportional to the amount of prothrombin present. The normal prothrombin time varies with the type of thromboplastin used so that controls must be run frequently; normal times are usually in the range of 18 to 20 seconds.

In jaundice, in which the prothrombin time is elevated, it is important to know if the prothrombin time will return to normal when adequate amounts of vitamin K are given parenterally; little change in the prolonged prothrombin time indicates severe hepatocellular damage, but rapid return to normal after administration of vitamin K indicates that the jaundice is most likely on an obstructive basis or that there is little or no damage to the liver cells.

TESTS OF LIPID METABOLISM

Determination of Cholesterol and Cholesterol Esters.—Cholesterol is a sterol found in all body tissues and fluids. The liver cells have the ability to esterify free cholesterol, and thus cholesterol esters are found to make up 70 to 76 per cent of the total cholesterol in persons with normal liver function.

Total cholesterol is determined by first extracting it from the plasma with alcohol, ether and chloroform. Acetic anhydride and sulfuric acid are then added, and a green color is produced. This is compared with the color of a standard solution. *Cholesterol esters* are determined by precipitating the free cholesterol with digitonin and then extracting the esters with petroleum ether. The amount of esters is then determined by the above-described color reaction. The normal value

for total and cholesterol is from 150 to 250 mg. per 100 cc. of plasma.

The value for blood cholesterol varies in a great many conditions. In obstructive jaundice there is a rise in the value for total cholesterol and also in the esters, so that there is little or no change in the ratio. Hepatocellular jaundice causes no change or a slight decrease in the content of total cholesterol, but there is a marked decrease in the amount of cholesterol esters present so that their percentage of the total is markedly decreased. This decrease is roughly proportional to the severity of the damage to the liver.

TESTS OF EXCRETION OF DYE

It has been found that a number of dyes are removed from the circulation and excreted by the liver. Two of these which are used clinically to evaluate the status of the liver are sulfobromophthalein sodium (bromsulfalein) and rose bengal. These dyes are rapidly removed from the circulation by the reticulo-endothelial system (Kupffer cells in the liver) and then are more slowly excreted in the bile after having passed through the hepatic cells.

In the sulfobromophthalein test 5 mg. of the dye per kilogram of body weight are injected intravenously and a reading is made of the amount of dye remaining in the serum after sixty minutes; normally there is no dye remaining in the serum at that time. Rose bengal is given intravenously in a dose of 10 cc. of 1 per cent solution. The amounts remaining in the serum are determined in two and six minutes respectively. In a normal person 50 per cent of the dye present in the two-minute sample will have been removed by the time six minutes have elapsed.

Dye excretion tests best indicate the status of the liver in cases in which there is little or no jaundice, although methods have been devised recently that are applicable even in the presence of jaundice. Whether jaundice is due to hepato-

cellular disease or obstruction to the bile ducts, there will be marked retention of dye so that as a test to differentiate these two types of jaundice, this type of procedure is of little value.

DETOXIFICATION TESTS

Hippuric Acid Test.—The liver acts to protect the body from certain toxic substances by causing conjugation to form relatively nontoxic substances which are excreted in the bile and urine. Some of these toxic substances are indol, salicylic acid and menthol. Benzoic acid has been used as a test of this function since it is conjugated with glycine, which is produced only by the liver, and is formed into hippuric acid in the liver and kidneys and is excreted as such in the urine.

The accuracy of this test depends on the ability of the kidney to excrete the hippuric acid; hence it is not recommended for patients who have an elevated value for nonprotein nitrogen. It also depends on an adequate output of urine and a complete emptying of the bladder. The benzoic acid can be given orally or intravenously but the intravenous method is the more sensitive. The oral test is done by giving the subject 6 gm. of sodium benzoate, and the urine is collected for the following four-hour period. With the intravenous method, 1.77 gm. of sodium benzoate is given, and the urine is collected for one hour. The hippuric acid is precipitated from the urine with ammonium sulfate and hydrochloric acid and is weighed. In the intravenous test, 0.7 to 1.2 gm. are excreted in an hour while with the oral test 3 to 4 gm. are excreted in four hours by the normal person.

Obstructive jaundice of short duration and hemolytic jaundice are associated with normal levels of excretion whereas all types of hepatocellular jaundice are associated with a marked decrease in the amount of hippuric acid excreted.

SERUM ALKALINE PHOSPHATASE TEST

Alkaline phosphatase, an exo-enzyme, is produced in the body mainly by the osteoblasts and

is excreted to a large extent by the liver. When abnormal osteoblastic activity is not present, elevation of the value for serum alkaline phosphatase is usually due to damage of the liver. The amount of alkaline phosphatase in the serum is determined by incubation of the serum with a glycerophosphate solution to produce inorganic phosphate (Bodansky method). The results are expressed in Bodansky units; 1 Bodansky unit is equivalent to 1 mg. of phosphorus liberated. Normal adults have 1.5 to 5 units of serum alkaline phosphatase per 100 cc. of serum.

In general, the test is not one of great diagnostic value in the differential diagnosis of jaundice. Elevations in the value for alkaline phosphatase do not parallel the degree of hepatocellular damage. The amount is usually normal in hemolytic jaundice, moderately increased in hepatocellular jaundice, and markedly increased in obstructive jaundice, but the increases are not constant enough to be of great diagnostic significance.

TESTS OF SERUM AMYLASE AND LIPASE

Amylase is found in the serum in remarkably constant amounts, and the amount is unaffected by food, starvation, diuresis or dehydration. The source has not been proved but it is suspected that amylase is produced mainly by the pancreas and the salivary glands. Obstruction of the pancreatic duct due to ligation or inflammation produces a pronounced elevation of the serum amylase levels, and similar elevations are found in acute epidemic parotitis. Sudden obstruction of the common bile duct or pancreatic duct will cause a decided increase but the effect is transient and normal levels are regained in seventy-two hours.

The serum amylase is determined on the basis of the length of time required for the amylase to digest a standard starch solution. The degree of digestion is determined by noting the change in color of a mixture of iodine and starch from blue to brown, when the starch is all digested. The

results are calculated by formula and are reported in units of amylase activity. The normal is 80 to 150 units, and to be clinically significant the value must be over 320 units. In the icteric patient, elevations are most commonly seen when the jaundice is obstructive in nature. The levels are usually normal in hemolytic and hepatocellular jaundice.

Like that for serum amylase, the value for serum lipase is elevated in the obstructive type of jaundice. The level of lipase activity is measured by the effect of the serum lipase on an olive oil emulsion to produce free fatty acids which are measured by titration with tenth-normal solution of sodium hydroxide. The results are reported in cubic centimeters of sodium hydroxide solution needed to neutralize the fatty acids produced by 1 cc. of serum. The normal is less than 0.3 cc. of tenth-normal solution of sodium hydroxide per cubic centimeters of serum, but the amount may rise as high as 10 cc. in cases of acute pancreatitis.

COMMENT

A review of the problem of diagnosis of the jaundiced patient, emphasizes the great value of a careful and complete physical examination and history. In many cases the diagnosis can be made by these means alone. However, in spite of the certainty with which one can make the diagnosis in many cases, routine liver function tests should be performed to confirm the diagnosis even when the clinical picture seems to make the etiology of the jaundice obvious. This may seem superfluous at times, but if the tests are done, some cases in which the clinical picture is entirely misleading will be uncovered and the cor-

rect diagnosis will be made, which may save the patient an unnecessary operation. In many cases the clinical picture will be inconclusive. In these cases the liver function tests are not used to support the diagnosis but are depended upon to establish the diagnosis. This they will do in most instances. In such cases the tests have proved invaluable. Finally in a few cases the laboratory tests as well as the history and physical examination will prove inconclusive. It is in these cases that surgical judgment and experience are invaluable, for surgical treatment may cause cure when correctly applied or injury to the patient when ill advised. Unfortunately, surgical judgment cannot be acquired from the printed page or in the laboratory. It is best developed by experience and, in particular, careful analysis of one's past errors.

SUMMARY

It has been pointed out that liver function tests, in addition to a complete history and physical examination, are of great importance in determining the etiologic factors which cause jaundice. To be of greatest aid, these tests should be performed as early in the course of jaundice as possible. The essential laboratory procedures which should be used for diagnosis in all cases of jaundice pertain to determination of the serum bilirubin, fecal urobilinogen, duodenal drainage, cephalin-cholesterol flocculation, thymol turbidity, zinc sulphate turbidity and prothrombin time. The essential principles and procedures of these tests and other tests have been presented so that they may be better understood, and the results of these tests in the various types of jaundice have been presented in tabular form.

SEMIANNUAL MEETING

Friday, September 12, 1952

Headquarters, Commander Hotel, Ocean City, Maryland

Guest speaker—WINGATE M. JOHNSON, M.D., from Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

Other special features to be announced.

MEDICINE'S NUMBER ONE PROBLEM¹

HOWARD A. RUSK, M.D.²

Medicine's number one problem today has been medically created. If we are to meet the problem, the leadership must come from medicine.

Medicine's number one problem is the problem of chronic disease in an aging population, made up of all the results of good medicine, a problem created by liver extract and insulin and x-ray techniques, and vitamins and penicillin, cortisone, ACTH, good x-ray and the type of cardiac surgery you developed here in Baltimore, and everything that has gone into making medical care in America what it is today.

For that reason, you can readily see what has happened. Two thousand years ago, man's expectancy was twenty-five. At the turn of the century, forty-nine. Last week it was seventy-one years for white women and sixty-five and a half years for white men, in the United States. A white man of sixty-five today, has an expectancy of twelve and four-tenths years and a white woman of almost fourteen and a half years.

Twenty-five per cent of the population in America in 1940 were beyond the age of forty-five. They required fifty per cent of the medical service. By 1980 almost fifty per cent of the population will be beyond the age of forty-five and they will require eighty per cent of the medical service.

If you want a figure to conjure with on your insomniac nights—and I'm not recommending it therapeutically—let me give you the veteran figures. At the end of World War II, there were

three million, four hundred thousand veterans from World War I still alive and their average age was fifty-three. In 2000 A.D., there will be three million seven hundred thousand veterans from World War II still alive, and their average age will be seventy-eight. This problem is not only medicine's number one problem but one of the primary problems in our economy because if we don't do something about the retirement willy-nilly at sixty-five, on the chronological rather than the physiological age; if we don't do something about utilizing our chronically ill within their capacity, and training our physically disabled and utilizing them in our own economy, by 1980, for every able-bodied worker in America, there will be one in those three categories on that worker's back.

I think one of the most interesting phenomena is, where did the year "sixty-five" come from? I've not been able to find it but I have a definite idea. I believe it came, not from a symposium of physiologists who came to a conclusion that this was the retirement age, I believe it came from a Board of Directors that had a meeting one day when the President was out of town, and he had been a mean old so-and-so for a long time. While he was away there suddenly decided here is a solution to our problem; we'll have compulsory retirement at sixty-five, and I think it has been pretty well followed since because there is no rhyme or reason nor magic to age sixty-five.

What would we have lost had Winston Churchill retired at sixty-five. We probably wouldn't be discussing the same things tonight that we are. And Mr. Bernard Baruch, we would have lost fourteen years of his wise counsel, including the rubber program and the Atomic Energy Program. I always think of Harvey Cushing. He went to Yale at sixty-five after he was retired from Harvard where he did most of

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his distinguished work. And Toscanini, who goes on barnstorming trips across the country is another example.

You know perfectly well that some people are old at forty, others young at seventy-five and it is a physiological rather than a chronological approach that we have to make.

I would say from my observation, that industry and labor and the politicians are crying to us in medicine today for some solution to this problem because you get to an end point in pensions rather quickly, and you can't see the end of the road unless these individuals can be utilized, can be evaluated, can be kept on.

You know perfectly well; you've seen them every day. Some individuals can hardly wait till the day they retire. They want to raise rabbits, peonies, or set up a store or go to Florida, or finish their stamp collection. Others loaf around the door of the office, waiting to see if business will close the day they don't come down, and usually they are not with us six months or a year from that day.

This is, I think, a medical and community responsibility. To me it is preventive medicine of the future. I want to give you one example of the experience we have had in New York, that will illustrate what I am talking about in preventive medicine.

I don't think that our primary problem is milk supply and water supply and immunization and all the things that we have known in the past. I think it is a decompression program for the older age group. It is a matter of adding life to years as we have added years to life.

Five years ago in New York, for a very interesting reason, we set up a community center for the older age group because in one welfare office in the Bronx they were mobbing the place all the time. The worker didn't have any chance to get work done with clients coming in all day with "The eggs were cold," "Miss So-and-so said something about me," "The roof leaked," "I didn't get my check" something or other.

It was decided to get three rooms in the old

City Hall and set up a community center where this old age group could go, and see if they could cut down the number of gripes. The ground rules were this: The club was self-operating; you had to be sixty to get into this group. They put in one worker; they got an old second-hand piano, a "beat-up" pool table, three or four card tables and they opened.

They now have had five years experience with seven hundred patients with average age seventy-six. The rules are they run their own program. They have a committee that visits the sick and sends birthday cards. The worker described it well to me: "The first three or four weeks, the old people come in, they are disturbed, they can't understand why anyone wants to do that for them. All of a sudden, the skin texture changes and they have a light in their eye, they are there when we open in the morning. The whole thing is that life is different." There have been eleven weddings since they opened five years ago. They are open from nine to five every day and have two dances a week.

But the payoff is this. In this age group, varying from sixty-six to eighty-eight, with an average age of seventy-six, admission to the general hospital for medical reasons in the last five years was fifty per cent below expectancy. The payoff was this—and I got this figure from the American Psychiatric: There should have been forty admissions to mental hospitals for senile psychosis in this age group in the past five years. There has not been one single admission. I got out my pencil and paper and here are the figures. To have kept the forty in that hospital at that time, it was ten thousand dollars more than the fifty cents per week per patient that it took to run the entire center. I give you the illustration because I think that sort of thinking has to spearhead the preventive medicine in the future if we are going to meet this particular problem. It takes medical leadership but community responsibility.

The part that we are particularly interested in, medically, are the problems of the chronically

ill and the physically disabled. The best figures that I can give you on the chronically ill, are from a survey made by the Department of Public Health in the Yale University College of Medicine within the last two years.

They found that one hundred twenty-one individuals per thousand population in New Haven were suffering from chronic disease or physical disability. Forty of the one hundred twenty were so severely ill or disabled, they were unable to work and forty were under the age of twenty-five.

We can never meet this problem, in my opinion, if we confine our thinking to hospital beds; to facilities; to places where these individuals can be hidden out and gotten out of sight. In the first place, there isn't enough money to build the beds if there were enough people to train and run the beds; if there were enough money to pay the people who were trained to run the beds, once they were trained. There just isn't enough. The veteran figures readily give you the index.

It is our deep feeling that this responsibility is an integral part of medical care, and we don't talk about rehabilitation any more because rehabilitation isn't a good word. Rehabilitation first was used to "cover the waterfront;" war-torn countries; social problems and hospital buildings. I got the payoff of payoffs a month or so ago when one of our patients said she could not go on the program, she had to have her wheelchair rehabilitated. Rehabilitation literally means returning one into his former state. Pretty poor program for the cerebral palsied child.

We talk about dynamic therapeutics in chronic disease. A third phase of medical care—the first being prevention—the second being definitive medicine and surgery, and the third being that thing which happens between the bed and the job. What do you do with what you have left? We feel it is an integral part of hospital care. Our service at Bellevue operates like a service department, just like x-ray and lab.

We bring patients into our Ward on one simple criteria—can we benefit these individuals by training; to let them live a fuller life?

We see all patients before they go on home care. If we can train an old multiple sclerotic or hemiplegic to meet his daily needs and walk about, it cuts the home care cost in half and that goes on for an indefinite period.

This is a program that has to be run by a team. The team comprises first, the doctor, and the doctor's training comprises first, a real understanding of basic medicine and from there he goes into the special techniques in the special field of rehabilitation. On his team is the physical therapist and the occupational therapist, the teacher and social worker, the nurse and the speech therapist and the vocational counselor. Recently, we have added a new service at Bellevue on a research basis, the job-placement counselor.

An individual comes into the service and in addition to the medical survey, he gets two or three very simple examinations. He gets a definitive muscle test: He gets a careful evaluation of range of motion of the joints. But the heart of our whole program is the simplest thing in the world. It is a test for a hundred inherent needs of daily living. Can you brush your teeth? Can you comb your hair? Can you turn from side to side in bed? Can you put on your own clothing? Can you put on your own braces? Can you get from bed to wheelchair, wheelchair to toilet, toilet to wheelchair, wheelchair to bathtub, bathtub to wheelchair? If you can stand, can you walk? If you can sit, can you stand? If you have to learn to walk, what kind of crutch gait? And there are some dozen that will meet your specific need. After you get the score, then you sit down and work out the program to meet that individual's need.

I'd like to talk clinical medicine for five minutes. I'd like to tell you about our hemiplegics. There are one million hemiplegics in the United States, more than ninety per cent of them due to cerebral vascular accidents; a large per cent

on a thrombotic basis due to arteriosclerosis. There are your "crocks," and I like John Romano's definition of a "crock." He defines a "crock" as the patient from whom the diagnostic sheen has been worn. Practically all of our patients are "crocks" and the hemiplegics are one of the best examples.

We have recently finished the evaluation of our first one hundred cases at Bellevue, typical Bellevue patients, average age sixty-three. They varied in age from eighteen to eighty-two. They varied in duration from one day to nineteen years. Forty per cent have had some degrees of aphasia. After their evaluation, they are started in a training program.

I'd like to say that speech therapy is the most neglected phase of medical therapy today. Our forty aphasics have given us a very graphic insight as to the problem; not as graphic as a young lawyer that I saw at a meeting in Chicago, six months ago, who had his thrombosis on a golf course; a very small lesion affecting primarily Broca's area. All of a sudden he was speechless and with a little weakness on one side.

He went to three doctors and it took five weeks before he obtained a definite diagnosis. The unfortunate thing is that in those five weeks, no one sat down and said to him, "you have aphasia, aphasia affects your speech. I know what it is, you're not losing your mind, no, you don't have softening of the brain. You aren't going crazy, and there's a way you can be taught to talk again. It's a long, painful process but we have taught patients in a period of six months to have a vocabulary of four to five hundred words who have been one-word aphasics for as long as twenty years. We are going to teach you as soon as you feel you are ready to come to classes; don't worry, you know and I also know what you have. I have an idea how frustrating it is because I know how frustrated I am when I can't remember somebody's name; and I know that you know that is a watch but that you can't say 'watch' and you and I understand each other."

If you do just that, half your battle is won. And if you are in the country where you don't have a speech therapist—and that is the answer they always come back with, "they aren't available" let me give you a tip. I may be right and I may be wrong. The horse races run near Baltimore, and you know what the odds are. If you will canvass your public schools, I'll give odds on a bet that you will find someone in the public school who has had training in speech and who can take on the basic program for the average aphasic. Such a person can give your patient the necessary care and relieve you of the burden and responsibility, and it will also give under-paid teachers a chance for a little extra work on their off hours.

We believe in early ambulation for hemiplegics except in hemorrhage, and of course you know the mortality of hemorrhage is more than eighty per cent.

We believe they should be kept in bed three weeks if they are frankly hemorrhagic. They should be kept in bed if it is necessary, for the systemic cause of the embolus. If they are thrombotic, we like to get them up on the day they become conscious. We like to start the program the day they come into the hospital. It is a very simple program.

First, you put a footboard on the foot of the bed to keep the covers off the toes, to keep from aggravating the foot drop. Second, you put a sandbag or a soft pillow (you can make an excellent one with discarded sponge rubber) in the axilla, one inside and one out, to prevent outward rotation of the shoulder. Do the same thing to the lower extremity to prevent outward rotation of the thigh, and start simple passive motion of the shoulder the first day. When the patient becomes conscious, get an old piece of pipe and bend a gooseneck to go over the bed, or use the sort of stand that you use to give glucose. If it is in the patient's home, get a shelf bracket and screw it in the wall over the bed. Either one is equally good. Get a ten cent window pulley and a dime's worth of clothesline rope, and that is

all you need to put over the patient's bed. Make a double loop so that one goes around the wrist and one around the palm of the hand, and as soon as the patient becomes conscious, start exercising the bad arm with the good. You get a double play because there's strength in the arm that is going to be their crutch hand and the shoulder won't freeze.

If a shoulder is left alone for one week, it will freeze wholly or in part, and will take from six to eight weeks of hard and painful work with the best therapist to get the shoulder unfrozen.

With pulley therapy, you will get fifty per cent more motion the first day you start than any trained therapist can give, because the patient knows his own pain threshold.

When you get the patient up to walk, there will be several things that will bother you. In the first place, a certain percentage will have clonus; if so, remember 90 per cent of the impulse of clonus comes from the toe, so get a little piece of board an inch wide and a quarter inch thick and take a piece of adhesive and fasten across the ball of a patient's foot. They will walk the "heel ball gait" rather than "heel toe gait" and you will find that ninety per cent of your clonus is well controlled within a period of a week.

Better control can be obtained with a short leg brace with a ninety degree stop and a pronator strap. We find that fifty per cent of our hemiplegics require such a support. The first reflex to come back in the foot is the climbing reflex. If you see some of your old hemiplegics with a foot drop, ask them to bring up their toe and they can't do it; ask them to bend their knee and you will find their foot will flex automatically in pronation.

If you don't put a brace on with a pronator strap, when they come down, they have instability with resultant falls and fractures. Use a short leg brace and a pronator strap and then teach the patient to walk with a bent knee. They'll never develop a normal gait if you keep them in a walker. You have to get reciprocal

gait the way you walk all the time. That is why we start all our patients in parallel bars. Not the gymnasium bars, but the kind the plumber can build with an inch and a half pipe and about three feet, six inches high. If it wears the skin off their hand, you can get an old leather glove and make a little curve around the pipe so they can slip along that way. It gives them balance and they get the reciprocal motion.

You will find also that the hands, ninety-nine per cent of the time will come back last. You will find also that if you see a patient in bed and he has quadriceps, if he can raise his leg, you can say accurately that that patient can be taught to walk.

When the hand begins to come back—following Sherrington's original work of the reinforced reflex—if you will have the individual, when he tries to do something with the effective hand, turn his head very sharply to the side of the effective hand, you will find that his strength will be from twenty-five to seventy-five per cent greater than if he head is turned to the opposite side

These are little tricks but if you put them all together, you will have the same experience we had, that is, ninety per cent of your hemiplegics can be taught self-care and ambulation, and in our experience, forty per cent will return to gainful employment.

Old hemiplegics with a "modicum," maybe a "soupcon" of cerebral degeneration may be seen lying around in the chronic wards, who are incontinents and whom you cannot train to primary continence. The incontinents will never be trained unless they are gotten on their feet. The same is true of paraplegics. Unless they are gotten on their feet and get the benefit of hydrostatic pressure, they will never be trained to automatic bladders.

Now we don't feel that vocation is the alpha omega of this program. We feel if we can take an old hemiplegic and train him to self care and relieve the nursing burden of institutional care, it is well worth our training time, which for the average hemiplegic is six weeks.

The same program with many variances is true for the quadriplegic. Quadriplegia isn't a hopeless problem. We have had twenty-one in the last year, and you will find if you evaluate your quadriplegics, that eighty per cent will come between the fifth and sixth cervical, and there is a very good anatomical and anthropological reason for that. You will find that about half come from automobile accidents, and thirty per cent of the rest will come from swimming accidents, and fifty per cent of the swimming accidents will come from surf rolls. Go into an ocean wave and your head acts as the handle of a whip, and your body as a whip.

Well, with special apparatus such as a large handle, knife, fork and spoon which you can hold, patients are taught to feed themselves, brush their teeth; comb their hair; ladies to make their facial toilet; men to shave; they can type with a little "dingus."

We have had an interesting experience with a girl who got out of Bellevue recently. This girl was twenty-six, a Nisei, who had broken her neck at the fifth and sixth cervical. We had her in a ward. It took five months to train her. She had all the classical things that I've described. She had a very difficult vocational problem because she was an artist, and we didn't think she could ever do commercial art again. She was a textile designer.

We have learned one thing in this program, don't tell people what they can't do unless you have tried them because you don't know. We made her a soft mit which went over her hand, and fastened with a thong which she could fasten herself. Two holes were placed in the end so that she could put a paint brush through, and we gave her some paints and said "try." Much to our surprise, she could paint practically as well as she did before she was hurt.

To make a long story short, she went home on home care. Her mother was able to quit her job, her younger brothers were able to come back in the home. She and her father make a living for the family, and the mother looks after the family

and they have been doing it now for six months. She was given a commission to do art work at home and she was good enough to get it on her own merit.

We don't have to apologize for the things that disabled people can do. Every survey that has ever been made on their utilization in industry has shown the same result, better production, lower accident, lower absentee and five to nine times less labor turnover than the normal individual working side by side with him.

If I could leave one thought with you tonight, I think I would rather leave this thought. The reason you do a good job practicing medicine is that nature has given all of us tremendous powers of over-compensation. The blind man learns to see with his sense of touch and his ears. The deaf man learns to hear with his eyes, and our paraplegics walk on their hands. Put a paraplegic on a stool where he can sit and use that tremendous over-developed skill and he can give the normal man cards and spades and outwork him any day in the week.

I have had this said many times, "Well, what are you going to do, this program sounds fine when full employment is here, but what are we going to do with these people when hard times come, when there aren't enough jobs for everybody?" It's a question that infuriates me. We are not asking for a head start. We are asking for an even start and any time that the normal can't meet the competition of the disabled person in this country, then we better give it back to the Indians and start over. Let them take their chance along with everybody else, but don't let them have two strikes on them before they come to bat.

We have had an interesting experience in the last six months with a research program that I think is just as fundamental as the first social service program that was started at the Massachusetts General Hospital fifty years ago.

A group of young veterans, business men, top young business men, formed a voluntary committee. It was headed by a man who had lost

one leg and most of the other in the battle of the Bulge. They met twice a month to help place our trained people in industry. They got so interested in it that they set it up as a research project, and now we have a bilateral amputee who heads it. He was formerly a personnel man in a large manufacturing concern in New York, who devotes his full time to it.

We have preferential employment for our people from Sperry Gyroscope, Grumman Aircraft, Gimbel Brothers, all the hotel industries in New York and including five labor unions, because they say that they know more about our

people and what they can do than the normal, both psychologically and physically. We say to them, if you've got a job, give them a chance, and if they can't deliver we'll take the terminal interview off your hands and we'll replace them ourselves. Since September when we started, we have not had to replace one single individual.

Ladies and Gentlemen, in my opinion, while this isn't as glamorous as high fever and the acute medical problems that we have been trained to feel was the epitome of professional mastery in the past, this is a responsibility we must accept because we have created it.

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PREPRINTS AVAILABLE FROM THE GENERAL ELECTRIC COMPANY

The General Electric Company is running a series of full page advertisements in *Newsweek*, designed to provide a better understanding and appreciation of the rôle of the medical profession in maintaining the nation's health. If you wish to obtain preprints for your reception room table, write to Mr. W. R. Petrie, Manager, Advertising and Sales Promotion, General Electric Company, X-ray Department, 4855 Electric Avenue, Milwaukee 14, Wisconsin.

A SPECIAL REQUEST!

The Surgical Section of the Baltimore City Medical Society has a very incomplete roster. It would be appreciated by the members of this Section if each member of the Baltimore City Medical Society who practices surgery would send his or her name and address to Dr. E. Roderick Shipley, 618 Medical Arts Building, Baltimore 1, Maryland.

The Surgical Section will appreciate receiving this information as soon as possible.

Reports

SUPPORT THE BLUE SHIELD

HOUSTON S. EVERETT, M.D.*

As this is July all of us engaged in the active practice of medicine have recently been called upon to renew our Federal narcotic licenses. In order to do this we have been required to obtain a certified check or postal money order for the sum of one dollar (\$1.00), it being stated in the regulations that personal checks or cash are not acceptable. (The same Department of Internal Revenue which handles this matter accepts personal checks for hundreds or thousands of dollars in payment of income tax.) Until last year in order to obtain renewal of the narcotic licence it was also necessary to obtain notarization of an inventory.

These small but time consuming annoyances are but minimal examples of the red tape that we as physicians would be subjected to, not yearly or even daily, but hourly should we ever come under regulation of the Federal Government by the terms of a plan of compulsory health insurance such as that advocated by our present socialistic administration.

Nevertheless the desirability of some method of provision for prepayment of the cost of possible expensive illness by voluntary insurance is almost universally recognized. No group has been quicker to recognize this need than have the members of our profession. Under the leadership of the profession, Hospital Service (Blue Cross) and Medical Service (Blue Shield) plans have been instituted in most of the states or communities of the country. While the Blue Cross plan was established quite early in Maryland it was less than two years ago, and after

prolonged efforts by two separate committees of our State Society, that a Blue Shield plan was finally established. The plan as finally established underwent gestation and delivery by a large committee representing a cross section of the profession of the state under the chairmanship, quite appropriately, of an able obstetrician, Dr. Louis H. Douglass.

In the numerous and long sessions of this Committee, of which the writer was a member, it soon became evident that no plan could ever be evolved which would be entirely satisfactory to the entire profession of the state in every detail. But a plan was evolved which eliminated objections to the point that it was adopted and established.

Eight of the twelve members of the Board of Directors of the Maryland Medical Service, Inc. have been appointed by the President of the Medical and Chirurgical Faculty of the State of Maryland. These men have rendered yeomen service and carefully guarded the interest of the profession. With the changing economic situation it became evident that for success of the organization certain changes were necessary. The power to make these changes without submission for referendum to the profession had been conferred upon the board of directors. This board, however, feeling that the good will of the profession was as essential to success as a sound financial basis, chose to submit their recommendations to the profession of the state at the annual meeting of the "Faculty" in April 1952.

For a time it seemed that a rehash of details objectionable to some small groups, such as had taken place in the original committee, might

* Member, Committee on Public Medical Education, Baltimore City Medical Society.

take place in the House of Delegates. This was overcome, however, and with some modifications the suggested changes were submitted for approval to the various component societies. Such approval has passed by a large majority.

By so doing the profession of the state has again taken a constructive step in combatting the threat of socialized medicine. Consider the

advantages: Red tape and paper work are kept to a minimum. While some fees are reduced the payment of a larger proportion of all fees is assured. Most important of all the conduct of our lives and work is still in our own hands without interference by that Behemoth, the Federal Government.

Continue to support the Blue Shield!

* * * *

SUMMER HOURS FOR THE FACULTY BUILDING

June 16, 1952 to October 1, 1952

Monday through Friday—9 a.m. to 5 p.m.

Saturday—9 a.m. to 1 p.m.

* * * * *

SUPREME COURT RULES IN FAVOR OF OREGON MEDICAL SOCIETY

Capitol Clinic, A. M. A., Bulletin No. 49—82nd Congress, May 1, 1952

The United States Supreme Court in a seven to one decision April 28, dismissed an appeal of the government against the Oregon State Medical Society, eight county medical societies, Oregon Physicians Service, and several physicians who are or were officials of these organizations. Previously a U. S. District Court had ruled against the government's antitrust violation charge and a direct appeal had been taken to the U. S. Supreme Court.

The controversy in Oregon began in 1936 when the medical society opposed contract practice of medicine sponsored by private firms and commercial insurance companies. At that time the medical society charged that medical treatment and service was dependent upon company approval and in some cases the advice of physicians was disregarded. The medical society raised the ethical objection that third parties were entering the doctor-patient relationship. The medical society in an effort to bring about reform of prepaid medical service within the State, decided in 1941 to render itself such service on a nonprofit basis. After seven years of successful operation of the society plan the government brought suit charging the society with monopolizing the business of providing prepaid medical care within the state.

The Supreme Court said at one point, "Objections of the organized medical profession to contract practice are both monetary and ethical. Such practice diverts patients from independent practitioners to contract doctors. It tends to standardize fees. The ethical objection has been that intervention by employer or insurance company makes a tripartite matter of the doctor-patient relation. Since the contract doctor owes his employment and looks for his pay to the employer or the insurance company rather than to the patient, he serves two masters with conflicting interests. In many cases companies assumed liability for medical or surgical service only if they approved the treatment in advance. There was evidence of instances where promptly needed treatment was delayed while obtaining company approval, and where a lay insurance official disapproved treatment advised by a doctor."

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

COUNTY PHYSICIAN REQUIREMENTS

Cumberland is in need of one chest surgeon, one neuro-surgeon and one orthopaedic surgeon, to adequately cover its needs.

* * *

The Allegany-Garrett County Medical Society held its regular monthly meeting on Friday, May 16, at 8:30 p.m. in the Memorial Hospital Nurses' auditorium.

Dr. Leon A. Kochman, Chief of the Arthritis Clinic at the University of Maryland, discussed "Arthritis in the Geriatric Patient." Dr. Kochman is one of the directors of the National Arthritis and Rheumatism Foundation and during the coming year will be making monthly visits to Cumberland, as part of his work in the Arthritis and Rheumatism Foundation.

Dr. D. P. Ray, Director of the Johnstown area blood bank was present, to discuss any problems concerning the several blood banks in Allegany and Garrett Counties.

* * *

CIVIL DEFENSE

Organization for Medical Care is being rapidly completed in Allegany County. There are approximately 80,000 people in the county, the largest unit being in Cumberland with a total population of 40,000 including the surrounding suburbs.

Cumberland will have four Casualty Clearing Stations, and one in Frostburg and also one in Westernport, Maryland.

The Assistant Director of Medical Services is Dr. William F. Williams, with Dr. William A. Van Ormer serving as Chief Deputy.

Dr. Richard A. Williams is Deputy Director for Administration.

Dr. Benedict Skitarelic is Chief of Biologic Warfare.

Dr. Emmett L. Jones is Chief of Medical Personnel.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D., *Journal Representative*

The new x-ray equipment has been finally installed at the Anne Arundel General Hospital. Progress is being made on the plans for the construction of the new wing of the Hospital, which is supposed to be started early this summer.

A dinner was given in honor of Dr. William J. French at Carvel Hall on the 21st of May. The dinner was sponsored by the Anne Arundel County Medical Society to pay tribute to a wonderful job done by Dr. French for the Medical profession in the county during the past sixteen years. For his services and in appreciation, a silver tray was presented by Dr. Emily H. Wilson. The State, as well as the County, was well represented and many eulogies were offered by the guests who included Dr. Claude R. Ball, senior medical officer of the Severn River Naval Command; Dr. Perry F. Prather, Deputy Director, State Department of Health; Dr. Huntington Williams, Commissioner of Health for Baltimore City; Dr. Edward Davens, Chief of the Bureau of Preventive Medicine; Dr. C. A. Perry, Chief of the Bureau of Laboratories, State Department of Health; Dr. John Whitridge, Jr., Consultant in Obstetrics for the State Department of Health and former Chief of Obstetrics at Anne Arundel General Hospital; Dr. Jean R. Stifler, Consultant in Pediatrics, State Department of Health; Dr. Paul A. Harper, Professor of Public Health Administration, Maternal and Child Health Division of the School of Hygiene and Public Health, of The Johns Hopkins University; and Dr. Amos F. Hutchins, Baltimore and Anne Arundel County physician; and Dr. Harold R. Bohlman. Dr. Stuart Christhilf served as toastmaster. Assisting him in planning the dinner were Dr. Emily H. Wilson, who was the President of the Society when plans were laid for the dinner, Dr. Robert S. G. Welch, Dr. Donald H. Hooker, and Dr. Elizabeth Peabody Trevett.

BALTIMORE CITY MEDICAL SOCIETY RADIOLOGICAL SECTION

RICHARD B. HANCHETT, M.D., *Secretary*

The April meeting of the Radiological Section of the Baltimore City Medical Society was held on Tuesday, the 15th. Our guest speaker was Dr. Kenneth Corrigan, Director of the Radiological Research Department of the Harper Hospital in Detroit, Michigan. His subject was "Radioactive Isotopes in Medicine," and he gave a particularly fine presentation.

He confined his talk, for the most part, to practical demonstrations of the use of radioactive isotope tracer techniques and the differential diagnosis of a number of pathological states, in particular, thyroid disease and mediastinal tumors. In the differential diagnosis of mediastinal tumors, which has long been a difficult task for radiologists and specialists in chest disease, radioactive isotope tracer technique can quite accurately separate the mass into one of three groups—lymphoma, aberrant thyroid or other lesions. This, in conjunction with other information obtained in the general workup of the patient, has been most useful.

Some of the studies performed on patients with thyroid disease have been quite spectacular, as aberrant adenomas of this gland have been found in areas far removed from the usual location through the use of sensitive detecting instruments. This gives the surgeon an ally in his treatment of thyroid disease. An example of this was the removal of toxic adenoma from the mediastinum and the posterior cervical region in a patient who had obvious clinical signs of hyperthyroidism but whose thyroid gland did not appear to be remarkable.

Dr. Corrigan emphasized the real work is just getting under way in this field and felt that in a relatively few years, radioactive isotope tracer techniques will be standard procedures. He pointed out that properly performed, there is no more exposure of radiation to the patient than that received from an ordinary x-ray examination.

BALTIMORE COUNTY MEDICAL SOCIETY

DONALD L. SOMERVILLE, M.D.

Journal Representative

The Baltimore County Medical Association held its May meeting at the Dundalk Y. M. C. A., and

due to the numerous and pressing items of business, the scheduled scientific portion was not presented. Outstanding among the matters discussed by the members present was the report of the Association's delegates to the Medical and Chirurgical Faculty, presented by one of the delegates, Dr. Melvin E. Davis. The members learned of the proposed changes in the Blue Shield eligibility requirements, and voted to raise the income level from \$3,600 to \$4,000. It was also voted to maintain the present flat rate \$100.00 fee for obstetrical services under the Blue Shield.

Much interest was shown in the proposal brought out at this meeting that the Presidency of the Medical and Chirurgical Faculty should alternate yearly between a representative from the City of Baltimore and a representative of the Counties. This was passed as a resolution to be sent to the Secretary of the Medical and Chirurgical Faculty as well as sent for reply to all the component Medical Associations in the various Counties. Similarly approved and acted upon was the idea that the members of the Faculty Council should be limited to two terms or a total of 6 consecutive years.

Dr. Samuel P. Scalia, Chairman of the Public Relations Committee, reported that the Association-sponsored County High School Art Contest would be judged late in May. The first prize is to be a \$50.00 U. S. Savings Bond, and the three winners will be invited, with the judges, to the June meeting.

The Association welcomed the new Assistant Health Officer, Dr. Robert T. Hyde, who recently began his new duties in the Baltimore County Health Department. Dr. Hyde had previously been engaged in tuberculosis control work in the Florida State Board of Health. His predecessor in Towson, Dr. James E. Peterman, is now in Newark, New Jersey, as District Health Officer for the Health Department of that State.

CARROLL COUNTY MEDICAL SOCIETY

W. H. FOARD, M.D., *Journal Representative*

Members of the Carroll County Medical Society were invited to attend a special meeting sponsored by the Frederick County Medical Society, on June 17th, at the Peter Pan Inn near Frederick.

The meeting was in honor of Dr. Victor Cullen. The program consisted of a Symposium on Tuberculosis.

The regular meeting of the Carroll County Medical Society was held on June 18th, at 1:00 p.m., at Hoffman Inn in Westminster. Our guest speaker was Dr. Howard B. Mays from Baltimore. He spoke to us on Genitourinary Problems.

HARFORD COUNTY MEDICAL SOCIETY

CHARLES R. HAYMAN, M.D., *Secretary*

A joint clinical meeting was held on May 23rd, with the staff of the Station Hospital, Aberdeen Proving Ground. Two very interesting military surgical cases were presented and discussed. Dinner was served at the hospital officers' mess.

KENT COUNTY MEDICAL SOCIETY

ROBERT E. ENSOR, M.D., *Journal Representative*

The Kent County News, Chestertown, Maryland, on Friday, May 16, 1952, published the following:

Dedication of the new wing of the Kent and Queen Anne's Hospital, which with other improvements made to existing facilities is being completed at a total cost of approximately \$170,000, is set for Saturday afternoon, May 17, at 2:30 p.m.

The principal speaker at the dedicatory ceremonies will be Dr. Donald Guthrie, Chief Surgeon at the Guthrie Clinic and Packer Hospital in Sayre, Pennsylvania.

While the new wing has not received final inspection prior to acceptance from the contractors, it is already in partial use and completion and full operation are expected in the near future.

Following the dedication ceremony the public has been invited to inspect the enlarged and renovated hospital and the visitors will be shown through the building by members of the staff and the Women's Auxiliary.

The new wing, which adds 28 beds to the hospital's capacity, bringing the total to 50, will cost approximately \$160,000. In addition some \$6,000 has been spent on modification of the existing building and an additional \$3,000 on improving the grounds.

Included in the new wing are the Smith-Hines Memorial Nursery, a suspect nursery, a formula room, a bottle preparation room, a central sterilizing room, a laundry, a new kitchen, a staff dining room, a dining room for help, 12 semi-private rooms, a male and a female ward, each with four beds.

Also in the new wing is an isolated obstetrical suite with a labor room, delivery room, scrub-up room, sub-sterilizing room and locker rooms for doctors and nurses.

In the remodeling of the old section, a recreation room for nurses, a directors' room, a room for the Women's Auxiliary's meetings, and private quarters for the night superintendent have been provided on the second floor.

The Kent and Queen Anne's Hospital was originally opened in the summer of 1934, manned largely by volunteer help and its work confined to minor operations. The original section cost \$13,000.

An addition, known as the Maxwell Surgical Wing, was completed and opened in May, 1941.

Dr. Guthrie, who will be the dedication speaker, is also professor of Clinical Surgery at the Graduate School of Medicine, University of Pennsylvania. He is a member of the American Surgical Association, Southern Surgical Association, Surgical Research Society, International Society of Surgery and a Governor of the American College of Surgeons. He is also an honorary member of the Royal Hungarian Society, the Royal Academy of Medicine in Rome and the Medical and Surgical Society of Rio de Janeiro.

The Guthrie Clinic, of which he was the founder, is patterned after the Mayo Clinic and maintains a staff of about forty physicians and surgeons, operating in conjunction with the Robert Packer Hospital.

Dr. Guthrie is well-known in Kent as one of the charter members of the Cedar Point Gun Club on East Neck Island. He is a keen sportsman and a lover of the Eastern Shore and has been interested in the growth of the local hospital for many years. He was a class-mate and close friend of the late Dr. Eldridge Eliason.

Library

OSLER FUNDS

It is our good fortune that the name of Osler will go down to the future generations of the Faculty with his name associated with Osler Hall, the Osler Endowment Fund and the Osler Testimonial Fund.

Dr. William Osler served on the library committee from 1892 to 1905. He witnessed many developments of the library, including expansion from a few thousand old books to 14,590 volumes, the removal from the basement of the old Maryland Historical Society to the new home at 847 North Eutaw Street in 1895 and from a collection of books without supervision to the employment of a trained librarian.

Dr. Osler, in speaking of the approaching centennial, said in 1897: "We can try in the centennial year to attain a proper endowment for the Faculty from our friends among the citizens. We shall need a larger hall, more in keeping with the rank and work of the profession of this city—quarters as complete as our brethren enjoy in Philadelphia and New York. And an endowment yielding a few thousand dollars annually is absolutely essential for the proper development of the library." At the centennial he gave the first thousand dollars toward such an endowment.

The founding of the Charles Frick Section of the library and the financial support of the library given by the Book and Journal Club are attributed to Dr. Osler, who also presented many rare items to the library.

On April 24, 1917, Dr. Henry Barton Jacobs, Secretary of the Osler Testimonial Fund, reported that the money remaining after the building of Osler Hall had been increased to nearly \$10,000 by the professional friends of Dr. Osler and that the Committee wished to present this fund to be known as

the Osler Testimonial Fund to the Faculty, the income to be devoted to the upkeep of Osler Hall and for the purchase of books for the library in the subjects of most interest to Dr. Osler.



WILLIAM OSLER TESTIMONIAL FUND BOOKPLATE

The bookplate was designed by Mr. Max Brödel

RECENT PUBLICATIONS BY FACULTY MEMBERS

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- Arnold, J. G., Jr., The End-results of surgery for protruded lumbar intervertebral discs, *Bull. School Med. Univ. Maryland* **37**: 3-8, January 1952
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- Brady, Leo, An Unusual complication following a Baldy-Webster uterine suspension, *Am. J. Obst. & Gynec.* **63**: 922-924, April 1952
- Eareckson, V. O., and Miller, J. M., Third-nerve palsy with sparing of pupil in diabetes mellitus, *Arch. Ophth.* **47**: 607-610, May 1952
- Feldman, Maurice, and Weinberg, Tobias, Aberrant pancreas: a cause of duodenal syndrome, *J. A. M. A.* **148**: 893-898, March 15, 1952
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- Zellmann, H. E., The Incidence of positive serologic tests for syphilis in the collagen diseases, *Am. J. Syph.* **36**: 163-166, March 1952

A SPECIAL REQUEST!

The Surgical Section of the Baltimore City Medical Society has a very incomplete roster. It would be appreciated by the members of this Section if each member of the Baltimore City Medical Society who practices surgery would send his or her name and address to Dr. E. Roderick Shipley, 618 Medical Arts Building, Baltimore 1, Maryland. The Surgical Section will appreciate receiving this information as soon as possible.

Civil Defense

MARYLAND

BRIGADIER GENERAL ROBERT P. WILLIAMS

On Friday evening, April 18, Brigadier General Robert P. Williams, Chief of Medical Services, Civil Defense of Maryland, gave a talk before the Baltimore City Medical Society at its semi-annual meeting at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street.

General Williams stated that Mr. Maurice Evans, of the British Home Office of Civil Defense, in studying the vital statistics of World War II arrived at the conclusion that the number of casualties suffered by London in all of the air bombardments of World War II would total less than those expected from a modern atomic bomb airburst over a large city such as Baltimore. This is the measure of the problem confronting the Medical Service of Civil Defense. London, after a severe raid, usually had several days in which to care for the injured. We must expect more casualties than she had in all of her raids and all of the wounded will be produced at one instant and all will need immediate attention.

To meet this problem, Medical Services of Civil Defense are divided into three large groups: first, the casualty clearing station, the mobile medical unit where the wounded first come under the care of doctors. This station is small, mobile and equipped so as to give emergency surgical treatment, particularly transfusions, treatment of extensive burns and splinting of fractures. The station is mobile so as to permit flexibility and to allow movement of the station to the vicinity of a mass of casualties. In this emergency treatment it is desired to reduce the time lapse between moment of injury and application of surgical procedures. Since the casualty clearing station has no counterpart in ordinary civilian medical service, greatest attention is being paid to the organization and training of these units. At the end of last year there were 59 of these stations, either wholly or partially manned, in Maryland. Since the first of the year, Baltimore City has increased its number from 4 to 45 and is rapidly proceeding with the organiza-

tion to reach a total of 97. At present it appears that the increase in casualty clearing stations since the first of the year represents more than 100 percent.

Cases that require more extensive surgery or longer hospitalization will be transferred to hospitals. These consist of both existing organizations and emergency hospitals. The goal is eight times the present capacity of our hospitals. Hospital administrators have surveyed their present plans and in most instances find that for emergency periods they can accommodate about twice their normal number. This is by the conversion of assembly rooms, recreation rooms into wards and placing of cots in lobbies and wide hallways. They are surveying other large buildings, particularly colleges and high schools, and planning their use as emergency hospitals. In addition, it is necessary to organize present staffs to serve all of the new installations. Baltimore City hospitals are at present preparing the answers to a questionnaire from the City Medical Director's office.

Finally, there is what Civil Defense calls Essential Community Services. That is, the care of the usual sick and injured, as distinct from those produced by enemy action. After all, a man is just as dead from a neglected appendix as he would be from a neglected bomb injury. Essential Community Services are of extreme importance in three ways: to effect the early return of workers to their duty, to reduce the load of patients in hospitals, and to support the morale of the community. This service will operate mainly on an out-patient basis, using community clinics and with the services of a minimum of doctors and nurses. A great deal of the essential community service will be performed by home nurses trained for this specific duty.

Maryland's Civil Defense Act directed the use of existing organizations to the maximum extent possible. Thus, the State and local health departments formed the framework for Civil Defense

Medical Service. Dr. Riley, Director, Maryland State Department of Health, is the State's Medical Deputy for Civil Defense. Dr. Huntington Williams, the Baltimore City's Commissioner of Health, heads that City's Civil Defense Medical Service, just as county health officers head the service in each of the counties. At the same time, maximum use has been made of the Medical and Chirurgical Faculty and the various medical societies. Dr. Williams has informed me in most enthusiastic terms of the cooperation and assistance which the Baltimore Civil Defense has received from the city's Medical Society. The Turner Committee developed the initial plan for Baltimore City and

membership of the medical society is supplying physicians for the hospital expansion program and the city's projected 97 casualty clearing stations. Without this help, the City would never have been able to progress as far as it's gone in the organization of its Civil Defense. It is hoped that the society will continue this support and that as rapidly as possible all members will volunteer their services and urge their assignment in Civil Defense units.

General Williams' talk was followed by the showing of colored motion pictures demonstrating pathology and the clinical problem presented by the atomic bomb and the use of medical services in atomic diaster.

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DEFENSE DEPARTMENT TO SURVEY COUNTRY'S RESEARCH POTENTIAL

Capitol Clinic, A. M. A., Vol. 3, No. 19, May 13, 1952

Approximately 5,000 industrial concerns will be surveyed by Defense Department's Research and Development Board to determine the nation's present and potential research capacity. Included will be pharmaceutical firms, as well as research foundations and private consulting groups. *In medical sciences*, the Board is interested in learning more about research capacity in the following fields: atomic medicine, antibiotics, aviation medicine, bacteriology, dentistry, disease (infectious, tropical, venereal and others), immunology, medical aspects of biological and chemical warfare, medical equipment, neuropsychiatry, pathology, physiology, prosthetic devices, sanitation, shock and transfusion, surgery and toxicology. Defense Department has budgeted \$35,000 for the survey, a final report on which is expected at the end of September. Returns will be kept confidential.

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F. S. A. OFFICIALS DISCUSS VOCATIONAL REHABILITATION BUDGET PROBLEMS

Capitol Clinic, A. M. A., Vol. 3, No. 18, May 6, 1952

Henry Viscardi, member of the ODM Task Force on the Handicapped and on the faculty of New York University Medical School, declared the greatest need today "in keeping with the advanced programs of physical medicine and rehabilitation is a changed concept which will place its greatest emphasis on an incentive for the injured worker to return to work." He described as "medieval" the physical standards applied for employment in American industry and commerce and called for a new concept of "changing the job to fit the worker."

Health Departments

DEPUTY STATE HEALTH DIRECTOR*

The Morning Herald, Hagerstown, Maryland, on Wednesday, April 2, 1952, published the following:

Dr. Perry F. Prather, Director of the Hagerstown and Washington County Department of Health, has been appointed Deputy Director of the Maryland State Department of Health. He will assume his new position on July 1.

Dr. Robert H. Riley, Director of the Maryland State Department of Health, in announcing Dr. Prather's appointment as deputy director, said:

"The State Department of Health is fortunate to be able to secure a man of such distinguished service in both the practice of medicine and active work in public health. Dr. Prather brings to his new task a full appreciation not only of the methods and techniques of public health, but of problems and attitudes of the medical practitioner."

Dr. Prather, who has been the city-county health director here since 1947, will succeed Dr. Dean Roberts, who has just been named Director of the Commission on Chronic Illness, a national agency. Dr. Roberts will leave his position with the State Department of Health to take his new post on July 1.

A member of the State Planning Commission on Medical Care and the Governor's Mental Hygiene Board of Review, Dr. Prather has had considerable statewide experience serving on these two boards, which he will bring to the State Health Department.

Dr. Prather also holds the Certificate of the American Board of Preventive Medicine and Public Health, which qualifies him as an expert in matters of Public Health.

The appointment of Dr. Prather was made by the State Board of Health, of which Dr. Riley is Chairman.

He will carry on the work of the Hagerstown and Washington County Health Departments until his successor is named.

Dr. Prather has been a practicing physician in Hagerstown since 1925 until his appointment five

years ago as director of health here. Prior to his appointment he had been City-County Deputy Health Officer for a year.

At the time he accepted the full time health post here, Dr. Prather withdrew from the practice of medicine in order to devote his entire time to public health work.

A consultant of the United States Public Health Service since 1940 in its pneumonia preventive program, Dr. Prather is co-author of studies on pneumococcus published by the U. S. Public Health Bulletin.

Dr. Prather had also been editor of the Current Medical Digest, published in Baltimore, for a number of years, since he accepted that post in 1929. As its editor he had kept in close touch with the latest developments in medical science. This medical magazine has a wide circulation among members of the medical profession not only in the United States, but in a number of foreign countries.

He also served a number of years as director of the Washington County V.D. clinic and also as visiting consultant of the V.D. clinic in Western Maryland.

Dr. Prather served in two wars. In World War I he was a Private First Class in the Medical Corps of the U. S. Army, serving 18 months overseas. He was battalion surgeon of the 6th. Battalion Maryland State Guard with the rank of major during World War II, under the command of Col. William Preston Lane, Jr.

Besides his wide activities, first in the practice of medicine, then as health officer, Dr. Prather gave considerable time to civic and governmental service. He served as a member of the Board of Street Commissioners of Hagerstown in the administration of Mayor Reuben Musey, serving as police commissioner for six years. He has been active in Boy Scout work, having been awarded the Silver Beaver award by the Boy Scouts of America for his valuable contributions in service to that organization.

Dr. Prather has been recognized nationally for his work in the public health field. In 1944, he was called to Washington to testify before the United

* Article supplied by W. D. Campbell, M.D., Journal Representative, Washington County Medical Society.

States Senate committee investigating wartime health, and his testimony was quoted by the press throughout the country.

While a practicing physician here, Dr. Prather's first love was public health.

Born in Clear Spring, in 1894, Dr. Prather was educated at Dickinson College and received his M.D., at the University of Pennsylvania Medical School in 1924. He served his internship at the University of Pennsylvania Hospital, coming to Hagerstown in 1925 to begin the practice of medicine.

Dr. Prather was chairman of the Hagerstown Chamber of Commerce Health Committee which twice won for Hagerstown honorable mention in the National Health Contest. He served as president of the Washington County Medical Society, is a Fellow of the American College of Physicians, a member of the Medical and Chirurgical Faculty of Maryland and has held quite a number of other key positions.

Dr. Prather's headquarters beginning July 1 will be in Baltimore, and he plans to take up his residence in that city next fall.

* * * * *

RELATIONSHIP BETWEEN INOCULATIONS AND POLIOMYELITIS*

Because of widespread discussion and public alarm last year concerning the possible relationship between various types of inoculations and poliomyelitis, the State and Territorial Health Officers Association asked the Public Health Service, Federal Security Agency, to sponsor a study of the question and issue a clarifying statement. Subsequently, the Public Health Service, on March 14, 1952, sponsored a meeting of 41 poliomyelitis investigators, epidemiologists, pediatricians, allergists and health officers. The National Foundation for Infantile Paralysis helped plan and participated in the conference.

The conference voted unanimously in favor of the conclusions contained in the following statement which has been accepted by the Public Health Service and transmitted to official health agencies, to the medical profession and to the general public.

There is no definite evidence that an increase in

the number of cases of poliomyelitis has occurred as a result of injections of vaccines, drugs, and other medicinal agents. There is evidence that injections for the prevention of diphtheria, whooping cough and possibly tetanus, when given during an epidemic of poliomyelitis, may, on rare occasions, localize the paralysis in the inoculated arm or leg. There is no satisfactory evidence that other types of injections have any effect on the localization, frequency, or severity of poliomyelitic paralysis. In the small number of persons with localization of paralysis in the inoculated limb, the injections, for the most part, were given about 7 to 21 days prior to onset, which corresponds to the usual incubation period of poliomyelitis. This has raised the question as to whether or not inoculated persons have a greater chance of contracting poliomyelitis during an epidemic.

There is as yet no final answer to this question, but it is a fact that, even if there should be an increased chance, it is extremely small. Many thousands of poliomyelitis cases occur every year among children who have not had any injections during the preceding few months, and thousands of children have received injections for whooping cough, diphtheria and tetanus during poliomyelitis epidemics and have not developed the disease.

Diphtheria, tetanus and whooping cough are serious diseases which can be prevented by immunization. Unchecked, these diseases present a far greater hazard than poliomyelitis. The benefits derived from immunization against these diseases far outweigh the questionably small increased chance of contracting poliomyelitis. However, even this questionable risk can be avoided by carrying out these immunizations when poliomyelitis is not epidemic in the community. There appears to be no good reason for withholding these immunizations during the summer months in communities that are not having an epidemic of poliomyelitis.

Furthermore, poliomyelitis is at all times so rare in infants under 6 months of age, and the danger from other infectious diseases, particularly whooping cough, is so great, that it is advisable to continue the immunization procedures for this age group even during a poliomyelitis epidemic. In adults also, poliomyelitis is relatively so infrequent, that when there is a need for immunizing or therapeutic injections, such injections should not be withheld.

* Federal Security Agency, Public Health Service, National Institutes of Health.

Certainly no parent should object and no physician should hesitate to administer a needed antibiotic, drug or other injection for treatment of disease at any time. When there is immediate danger from diphtheria, whooping cough or tetanus, the preventive inoculations should be given to all threatened age groups even during a poliomyelitis epidemic. In the final analysis the decision as to when

an immunizing or therapeutic injection shall be given to an individual patient must rest with the physician.



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U. S CHAMBER OF COMMERCE ADVOCATES DRAFT DEFERMENTS FOR MEDICAL STUDENTS

Capitol Clinic, A. M. A., Vol. 3, No. 18, May 6, 1952

At its annual meeting here, *U. S. Chamber of Commerce* went on record in support of Selective Service, rather than Universal Military Training, as the best and most economical method of supplementing voluntary entry into the armed forces. At the same time, the Chamber stated that any induction system should permit deferment of sufficient numbers of medical students and those conducting research in medicine. On the question of UMT, the Chamber's board of directors voted to conduct a referendum among member organizations. The Chamber has supported the principle of UMT for many years.

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SENATE COMMITTEE APPROVES CONTINUATION OF SPECIAL PAY FOR DOCTORS

Capitol Clinic, A. M. A., Vol. 3, No. 18, May 6, 1952

The full Senate Armed Services Committee has approved S.3019, introduced by Senator Lester Hunt (D., Wyo.), which would extend from September 1, 1952, to July 1, 1953, authorization under which Armed Services and Public Health Service physicians and dentists receive a *special payment of \$100 per month*. The effect of this is to separate the physician-dentist special pay issue from the question of incentive and hazard pay for submarine service, flying and similar duty. Now the Senate will have an opportunity to vote on special doctor-dentist pay without reference to the other questions. In addition to continuing the extra pay for physicians and dentists, Senator Hunt's bill would extend it to retired regular officers who return to active duty and to physicians or dentists inducted by Selective Service under the Doctor-Draft Act and subsequently commissioned.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4 Week Period, May 2-29, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County.....	35	—	10	2	99	1	3	—	—	20	—	—	2	13	—	14	—	5
Anne Arundel.....	18	—	4	—	27	1	10	—	—	11	—	—	1	6	—	2	m-4	2
Howard.....	2	—	—	—	1	—	—	—	—	1	—	—	—	3	—	—	—	1
Harford.....	9	—	22	4	21	—	6	—	—	5	—	1	1	2	—	2	m-3	—
Carroll.....	14	—	1	—	38	—	8	—	—	1	—	—	—	2	—	—	—	2
Frederick.....	5	—	2	—	22	—	13	—	—	11	—	1	1	3	—	1	—	3
Washington.....	3	—	1	—	44	1	1	—	—	—	—	—	—	4	—	3	—	1
Allegany.....	—	—	—	—	2	—	—	—	—	2	—	—	—	3	—	—	—	2
Garrett.....	1	—	10	—	18	—	—	—	—	—	—	—	7	—	—	—	—	—
Montgomery.....	7	—	9	2	32	1	3	—	—	3	—	—	—	24	1	—	m-1	2
Pr. George's.....	10	—	15	—	20	—	7	—	—	5	—	—	—	9	1	—	—	3
Calvert.....	—	—	—	—	—	—	—	—	—	5	—	—	—	—	—	—	—	—
Charles.....	—	—	—	—	4	—	1	—	—	—	—	—	—	—	—	—	—	—
Saint Mary's.....	2	—	1	—	7	—	—	—	1	—	—	—	1	3	—	—	—	1
Cecil.....	—	—	—	—	1	—	—	—	—	2	—	—	—	5	—	3	—	1
Kent.....	—	—	1	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	—	—	2	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline.....	—	—	—	—	1	—	—	—	—	—	—	—	—	6	—	2	—	—
Talbot.....	—	—	—	—	2	—	—	—	—	1	—	—	—	1	—	—	—	—
Dorchester.....	1	—	—	—	1	—	—	—	—	—	—	—	—	—	—	1	—	—
Wicomico.....	1	—	3	—	36	—	—	—	—	1	—	—	—	2	1	15	—	—
Worcester.....	1	—	—	—	3	—	—	—	—	—	—	—	—	1	1	—	c-1	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	5	—	—
Total Counties.....	109	0	79	8	382	4	52	0	1	68	0	2	13	88	4	48		23
Baltimore City.....	239	0	51	12	272	4	32	0	0	53	0	0	13	112	9	518		14
State																		
May 2-29, 1952.....	348	0	130	20	654	8	84	0	1	121	0	2	26	200	13	566		37
Same period 1951.....	383	1	226	19	1051	3	488	1	7	107	2	3	29	225	38	557		37
5-year median.....	428	11	70	—	655	11	180	1	7	98	2	3	70	238	106	530		39
Cumulative totals																		
State																		
Year 1952 to date.....	2334	5	697	122	8611	58	657	7	1	722	8	11	102	1183	74	2755		382
Same period 1951.....	2282	26	663	120	2641	34	2934	11	8	616	8	12	265	1128	160	2889		300
5-year median.....	2683	119	317	—	2472	76	853	2	8	769	10	23	519	1203	642	2846		392

c = congenital syphilis under 1 year of age.
m = malaria contracted outside the U. S. A.

BLUE CROSS AND BLUE SHIELD

BLUE CROSS

R. H. DABNEY*

Blue Cross service benefits are unique.

By service benefits we mean benefits which are in terms of hospital service, rather than a cash indemnity, and are guaranteed by the participating hospitals through contractual arrangement between hospitals and the Plan. This is an agreement with the subscriber and the Plan, listing benefits to which the subscriber is entitled, such as, room, meals, general nursing care, operating room, anesthesia, drugs and other customary hospital services in a semi-private room, for 21 days.

When a subscriber has occasion to be hospitalized he may choose any member hospital of the Plan subject to his physician's referral. Upon admission to the hospital he presents his Blue Cross identification card and no further credit reference is required by the hospital. Upon discharge he is billed by the hospital for only such special services which may not be included in his Blue Cross contract, his eligibility for care having been confirmed by the Plan during his stay.

The service benefit principle of Blue Cross works to the advantage of the subscriber in several ways. First, his Blue Cross card serves as an adequate credit reference upon admission to the hospital. Second, he need not lay out cash for the whole hospital bill. Third, the benefits are more liberal since certain hospital services are provided regardless of cost. Under the Blue Cross service benefit

contract, hospital care is available to subscribers in member hospitals to the extent that it is needed without being restricted to a limited number of dollars per day. This is an important factor because no one individual can foresee when he will need care or what it will cost.

In these days of inflation Blue Cross is more valuable than ever before. Hospitals too have reflected the effects of these inflationary times. Nationwide, it is estimated that expenditures of all hospitals increased 215 per cent between 1940 and 1949 while the number of patient days of care increased only 20 per cent. These expenses must be passed on to the patient. Through service benefits the subscriber can be guaranteed complete coverage of his bill regardless of the rise in hospital costs. Blue Cross is buying hospital services at ever rising prices and still giving the same benefits instead of just a certain number of dollars which may or may not cover the bill.

Aside from the patient, Blue Cross means much to the hospital. It is the hospitals' credit agency and thus helps the hospital make available to the community its full facilities.

The hospital has a duty to its community and never turns away a person needing care. Its primary obligation to society is to make available to the ill all services possible. However, this cannot be done without adequate funds. It was precisely this situation that brought about the development of Maryland's Blue Cross in 1937. The hospitals created this Plan as a means to continue to give the community the best of care and to afford it a way to pay for that care.

P.S. The best patient is a worry-free patient and such a patient is a Blue Cross member.

* Executive Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

Hospital News

TRENDS IN HOSPITAL OUT-PATIENT CARE

MERRELL L. STOUT, M.D.* AND MRS. PAULINE NEWELL†

There are offered in this paper certain observations concerning 600 consecutive patients who recently presented themselves for care in the Out-Patient Department of the Hospital for the Women of Maryland.

The Hospital for the Women of Maryland is a general hospital for white women in a residential section of Baltimore offering medical, general surgical, gynecological and obstetrical care, which in 1951 had approximately 15,400 visits to its out-patient department.

At the outset a word should be said regarding the general policy of our clinic on eligibility. We start with the assumption that the average family with a "normal" amount of illness can and does afford private medical care for itself. It has a family physician to call upon when illness overtakes it. Recent census figures show that the average household in Baltimore has an annual income of \$3,218.00 per year, or about \$62.00 a week. Although we have not made a statistical study of our cases, it would appear that the majority of patients applying for dispensary care here at this time falls into this category, or slightly below it.

Rather than set up a rigid scale for measuring patients' eligibility by income, we have preferred to consider applications on a case by case basis, as determined by the patient's statements on her written application, which is supplemented, when time permits by an interview with an experienced social worker.

We have assumed that a typical family of two parents and two children, whose income is below the \$62.00 a week average, is eligible for dispensary

care when they request it. The standards set up for medical indigency by the State and City are admittedly too low and too rigid to be realistic. There, for instance, a family of four must have an income of less than \$40.00 a week to be eligible for free or part-free out-patient care. In the hundreds of cases we have interviewed in the dispensary we have found very few who have been able to save anything beyond minimum insurance payments on wages of \$40.00 to \$62.00 a week. The large majority of younger families with children are heavily in debt. Hence, even though they may be insured for hospitalization, there is no margin for medical care on an out-patient basis. They can usually pay for medicine and dispensary visits out of current income, but sometimes require special help for X-rays or special treatments.

In passing upon applications for dispensary care we consider, in addition to income (a) prognosis for economic improvement, (b) patient's resources, debts and obligations, including hospitalization insurance and (c) availability of medical care elsewhere. We always accept patients needing emergency treatment and patients referred to us by private doctors if our facilities meet the requirements of the case. In the case of patients with hospitalization insurance we explain what they can get under their coverage and if they have medical fee coverage we encourage them to take advantage of it. However, hospital insurance does not solve the problem of expensive out-patient treatments; in fact, keeping up premiums lessens the amount a patient has for same. For the large majority of applicants the fact of hospital insurance does not figure much in their wish for clinic care.

Our fees for a first examination are two and three dollars, depending on the type of case, surgical or

* Director, Hospital for the Women of Maryland.

† Chief Social Service Worker, Hospital for the Women of Maryland.

medical. The social worker is authorized to lower or waive payment of fees in cases of apparent hardship. For some of these cases in the lowest income brackets the hospital is partially reimbursed under the Medical Care Plan of the State of Maryland and the City of Baltimore.

We have many applications for dispensary care from families whose income is over the "average". Three factors bring them to us instead of a private doctor's office:

- (1) Above "average" need for medical care. These are the patients who have a family doctor for usual illnesses, but who cannot afford a specialist, or the ones whose illnesses are chronic, or require expensive diet, drugs or treatments.
- (2) Exceptional financial burdens or family problems. This group includes people who have been subject to unusual accidents, loss or illness or who, though normally in better circumstances, are going through a period of readjustment such as divorce, separation or reunion by reason of military service, and the like. They also include a group of unstable people such as the alcoholic who earns well but fails to support; the unmarried mother unable to go to her family for help, etcetera.
- (3) Preference for clinic care over private care: The majority of this group come because they want a "thorough examination" or a "complete check-up" which they have not been able to get, or think they could not get, from their family doctor. They are "willing to pay whatever we ask"—most of them seem to have given little thought to the fact that they are asking for a subsidized service, and that they are not paying full costs. They come because they have confidence in the clinic procedures. They express appreciation for the time given them, for the interest shown, for the possibility of complete diagnostic work under one roof (the fact that they may have to see different doctors, as the house men rotate to various services, does not trouble them—they still think they get better care). Among this group are a number of malcontents and neurotics who must "shop around", because—even though having been told many times that they have no physical disease needing treatment,

they are still sick. (May we add that quite a few of these settle down here!). There are a few, like minister's wives and wives of students, who could go to private doctors and receive professional courtesy, but who prefer to come to clinic and pay for what they require. There are also many who have been educated to want more than they are getting in the office of their private doctor, e.g. "I have asked my doctor why I cannot have children and he just laughs me off". "I was told that bleeding was a danger sign and asked for a pelvic examination. The doctor put me on the table with my corset on—and I don't think I had a thorough examination"... etcetera.

In the case of people in the category of being able to pay private fees but preferring clinic care, we try to refer them to a private doctor if they have none. If they have a family doctor we urge them to consult him about a referral to us or to a specialist or private clinic. We only accept patients from this category if it seems that real harm could be done through lack of immediate attention.

Now with regard to the 600 patients mentioned in our series, a questionnaire was devised for new patients and those returning after a lapse of at least a year, which went carefully into the family financial status, type of insurance carried, etcetera, and asked the specific question "Why are you coming to this clinic rather than going to a private physician?" The answers were somewhat startling, since out of the 600 queried, only 375 or 62.5% stated that they could not afford a private physician and the remaining 225 or 37.5% of the total said that they frankly preferred clinic care. With persuasion on the part of the social worker, 69 of these women were referred to men on our visiting staff, or returned to their family doctor, while 156 remained firm in their choice of the clinic, and were accepted as being at least on the borderline of eligibility.

It is interesting to note further that of the 375 considering themselves medically indigent (which opinion was concurred in by our social worker) only 134 or 36% had previously been to a private doctor during the past year, while almost 100% of the other group had had recent experience with a private physician.

Investigation of the prevalence of insurance in

the two groups revealed the following figures: Among the 375 medically indigent patients 158 (42%) had Blue Cross, 27 (7%) Blue Shield and 52 (14%) commercial insurance, while in the 225 preferring clinic care—of which 69 were referred to a private doctor—133 (59%) had Blue Cross, 31 (14%) had Blue Shield and 35 (15%) had commercial coverage

An analysis of the reasons given above why these people preferred clinic to private care was revealing. Far and away the most frequent answer was to the effect that the private physician keeps the patient returning to his office frequently without seeming to do anything for her. Numerous responses seemed to indicate that the patient desired a thorough examination and was often simply given some medicine and told to return later. Several patients expressed the opinion that they preferred the clinic because they then would not have to go first to one doctor for a blood test and then to another for an X-ray, etcetera. Quite a number really seemed to have a grasp of what group medicine means in that they felt more secure in a place where they knew the physicians (though relatively young house officers) were attempting to be specialists in their chosen fields and recognized the team work principle which is the keystone of group practise. These were also those who frankly stated that they thought the younger man, when in doubt, would call more frequently for help and consultation in

obscure cases. Of 375 medically indigent cases 134 stated that while they could afford and wanted "ordinary medical care" from private physicians, they could not afford specialists' fees and, therefore, came to the clinic for help. As a matter of fact, 54 of the 134 were definitely referred by private physicians for that reason.

From the above it would certainly seem that the main reason for applying for clinic care is financial stress. It would likewise appear that while the "relief" offered by hospitalization insurance has little effect, the carrying of Blue Shield tends to incline the patient toward private care.

On the other hand, the 156 cases who were borderline financial problems but who preferred the clinic and could not be persuaded to go elsewhere, 70% of the total preferring Clinic Care) deserve some thought. For while, of course, it may very well be that there are some "chiselers" in this group, one cannot help but feel that a little more patience on the part of the private practitioner and a little more thoroughness would have kept some of these patients away from the clinic, especially since our records show that many of these patients have been to private practitioners who are known to have very busy office practices.

In conclusion, it would still seem that there is a definite place for both clinic and private practice in our community and that the two should try to work more as a team and less as rivals in "guarding the health of Baltimore."

* * * * *

70% OF FEDERAL CIVIL DEFENSE FUNDS GO FOR MEDICAL PURPOSES

Capitol Clinic, A. M. A., Vol. 3, No. 17, April 29, 1952

Approximately 70% of all federal money spent on civil defense is going for *medical purposes*, principally matching grants to states for local medical stockpiling and all-federal regional stockpiles. This breakdown of Federal Civil Defense Administration activities is contained in Administrator Millard Caldwell's annual report, covering the first full year's operations of FCDA. So far FCDA appropriations for all purposes have totaled about \$100 million. Of this, \$50 million is earmarked for all-federal medical purchases. \$20 million will be used either for federal medical purchases or matching grants to states.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

ANNUAL REPORTS FROM THE COM- PONENT PRESIDENTS

BALTIMORE CITY, MRS. H. HANFORD HOPKINS

During the past year the speakers at our meetings have discussed various current health problems. Dr. Lillian Davis, Director of Health Education in the Baltimore City Schools, explained "The Narcotic Situation in the Schools." Dr. John Krantz spoke on "Physicians, Potions, People and Their Purses." At a subsequent meeting Mr. John Paine of the Baltimore Good Will Industries, gave us "Good Will the American Way," and at the Annual Meeting Mrs. Harold F. Wahlquist, National President, Woman's Auxiliary to the American Medical Association, spoke on "Working Together for Health."

It has been an interesting year for the Woman's Auxiliary to the Baltimore City Medical Society!

BALTIMORE COUNTY, MRS. MARTIN E. STROBEL

As a result of the Doctor's Day Dance held in March, 1951, we were able to finance our first Nursing Scholarship. The recipient of the scholarship, Miss Patricia Lefell, of White Hall, Maryland, is now in training at the University Hospital.

An exhibit was held at the Maryland State Annual Fair at Timonium, Maryland, during its eleven-day program from August 29, to September 8, 1951. Approximately 14,000 pieces of literature were distributed. These pamphlets were titled, "What about This Doctor Shortage" by Dr. Paul de Kruif, and "Socialized Medicine is No Bargain" by William L. Hutcheson, Vice-President of the American Federation of Labor. Three films were shown. One was on narcotics addiction, another was on the use of animals in medical research, and the third showed the disadvantages of socialized medicine.

We are having four meetings a year. Mrs. George E. Urban, our former President, entertained our

Auxiliary at her home in December with a most enjoyable Christmas party. At the February meeting, a motion picture entitled "Breast Self-examination" was shown through the courtesy of the Baltimore County Chapter of the American Cancer Society. Dr. William H. F. Warthen, Health Officer of Baltimore County, was present and conducted a discussion of the film.

Our Second Annual Doctor's Day Dance was held on March 29, 1952, for the benefit of a second Nursing Scholarship.

FREDERICK COUNTY, MRS. A. AUSTIN PEARRE

In the Autumn of 1951, when clubs and organizations were beginning to make plans for the coming year, the Woman's Auxiliary to the Frederick County Medical Society was slow in getting under way.

Mrs. Howard Ash, our very capable President, was preparing to move away from Frederick, so there was no May meeting and no election. The credit for our re-organization should probably go to the Washington County Auxiliary because late in October an invitation came for us to join them for a dinner meeting at the Fountainhead Country Club in Hagerstown. Twelve doctors' wives from Frederick went over for this very delightful affair and enjoyed a most interesting program.

Now that we are organized again, we are working with Student Nurses, whom we claim as our particular project just now. We have also given funds to the Nurses Medical Library.

It seemed we must wait until the first of the year to begin our serious work, but we did send the Nurses' Home, at Christmas time, a large painted tray filled with cookies donated by the members of the Auxiliary. An attractive addition to this gift was a center grouping of choir boy figurines, the artistic work of Mrs. Talbot Brice, one of our members.

During January and most of February all efforts were bent toward a fund-raising fashion show luncheon, which was held at the Francis Scott Key Hotel on February 20th. It was our pleasure to have as our guests at this time the President of the State Auxiliary, Mrs. George H. Yeager, and the State Chairman for Revisions and Resolutions, Mrs. Amos R. Koontz. These luncheons have become an integral part of the social life of the community, with tickets greatly in demand. The proceeds from this show amounted to \$212.50, to which we will add whatever we obtain from a benefit showing of the British film "The Lavender Hill Mob."

On March 25th, when Governor Theodore R. McKeldin presented to Dr. J. Albert Chatard, who represented the Faculty, a scroll proclaiming March 30th as Doctor's Day in Maryland, the President and Publicity Chairman of the Frederick County Auxiliary were present. A news article subsequently appeared in our local papers concerning Doctor's Day.

At the close of our February meeting we were joined for tea by the President of the Hospital Board, the Superintendent of Nurses and the Director of Nurses, whom many of our members had never met. The compliment was returned on April 17th, when the Student Nurses Association entertained us at a delightful tea, honoring the Auxiliary along with members of the Board of Managers! We like to feel that our project has thus contributed toward the warm feeling which exists between the Student Nurses and the Auxiliary.

Success in this effort encourages us to feel that during the coming year, we can effectively broaden the scope of our activities.

MONTGOMERY COUNTY, MRS. JAMES P. KERR

Our two main objectives for this year were, our "Membership Drive," which was very successful, bringing our total to thirty-six. Our second aim was a "Nurse Recruitment" Program to establish a Nurse Scholarship. We decided to serve a luncheon at our monthly meetings. This is managed by two hostesses and a co-hostess. Each member pays for her lunch, however, and the profit is put into a fund for a scholarship. At present our total is \$200.00, which we think is a good start in the right direction. Our luncheons have served a two-fold purpose in that we have a social hour before the business session,

which helps since we are widespread over a large county, and, also, we have stimulated new interest in that we have activity and objectives.

We follow the State programs as suggested and also have had excellent speakers at our meetings.

We have been invited to be luncheon guests of the District of Columbia Woman's Auxiliary in order to become acquainted with our neighbors.

All in all, I feel we have had a most enjoyable and successful year.

PRINCE GEORGE'S COUNTY, MRS. S. JACK SUGAR

The Woman's Auxiliary to the Prince George's County Medical Society has an enrollment of forty-two. The meetings are held monthly from September to June. New officers are elected in May. This procedure allows the new president a chance to appoint committee chairmen and start effectively organizing new activities before the group disbands for the summer.

An attempt is made to vary the type of program, entertainment and meeting places. Some meetings are held in the members' homes, as luncheon or dessert meetings. Others are held in the Doctors' Conference Room at the Prince George's Hospital. Mrs. George H. Yeager, President of the Auxiliary to the Medical and Chirurgical Faculty of Maryland, was the guest speaker at our opening fall meeting in September.

In October, a group of members representing the Auxiliary, donated blood to the Red Cross Bloodmobile. Several members give many hours each week to work with the Bloodmobile and other Red Cross activities. A number of our members belong to the Prince George's Hospital Guild and work in varying capacities in the Hospital. In May, 1951, the sum of \$100.00 was donated to the County Health Drives.

Our biggest public relations project of this year is to sponsor a 3-year Nurse's Scholarship to a deserving girl who will graduate from one of the County High Schools this spring. Mrs. W. B. Moyers, Chairman of this Committee, is working with the Superintendent of the County Board of Education to help to find us the right girl for our scholarship. The fund is \$250.00 and the money has already been raised by our hardworking Ways and Means Committee. We sincerely hope that the young lady will return to Prince George's County to

practice her profession, as our Hospital is desperately in need of nurses.

Subscriptions to "Today's Health" have again been sent to the Supervisor of Health Education in the County Board of Education for her work in the schools.

At our Christmas party, a special committee collected food, clothes and money to care for a motherless family of six children and an invalid father. The Auxiliary adopted this family, and parcels of food are taken to them from time to time. At the same time, several bundles of clothes and toys were given to the County Welfare Board to be distributed among needy families.

By the end of this year, the Auxiliary will have had five luncheons, a Christmas party, a benefit luncheon and fashion show, and a benefit tea. The members take turns, in groups, as hostesses at all meetings, and a feeling of congeniality and friendship exists within the group.

The Auxiliary policy of collecting drug samples and medical periodicals to send abroad has been continued this year.

There is a genuine feeling of co-operation between the Medical Society and the Auxiliary. Our common interest in the Prince George's General Hospital brings us closely together, as both our husbands and members are active in the support of this institution. When the new wing of 125 beds was opened in May 1951, the Auxiliary members were asked to assist as Guides for the public. This year, the Auxiliary again contributed \$100.00 for Medical Journals and Books to the Doctors' Library in the hospital.

Doctor's Day was celebrated on Monday, March 31st. The Auxiliary and Mr. Harry W. Penn, Jr., Superintendent of the Hospital, invited all the doctors in the County and on the Hospital Staff to a buffet luncheon at the Hospital. All doctors entering the Hospital that day were pinned with red carnations by Auxiliary members. Several County and Washington newspapers carried publicity on our Doctor's Day Program, both before and after the celebration.

The legislative chairman has kept members informed on pending legislation. In April, our Auxiliary was invited to meet with the Auxiliary of the District of Columbia Medical Society to hear former

Congressman Jennings Randolph speak on "Our Obligations as Voters."

Our meetings and benefit affairs have been covered in the County and Washington newspapers. Information concerning our activities and affairs have been sent to the State Publicity Chairman for use in the Journal of the Medical and Chirurgical Faculty of Maryland.

WASHINGTON COUNTY, MRS. S. ROBERT WELLS

Our total membership is fifty-nine, a gain of nine members over last year. We have thirty-six "Bulletin" subscriptions, and six "Today's Health" subscriptions. The new "Today's Health" Chairman plans to contact each doctor and ask him to subscribe at the full rate so that we may retain one-half the subscription rate toward a Nursing Scholarship. A "Today's Health" exhibit (mobile unit) was shown at the state meeting of the American Academy of General Practice, to be held in Hagerstown, on May 15th. We have received *full* newspaper coverage on every activity of the local chapter of the Auxiliary, as well as partial coverage on state and national activities. Our radio publicity on "Doctor's Day" was outstanding.

Under the supervision of the Chairman, during the Cancer Fund Drive, between forty and fifty women staffed the main Collection Booth downtown. Literature and drugs are being collected and sent for overseas use. As a matter of fact, all our members are doing their part in Public Relations, and are very active in community and church affairs.

Our Committee on Nurse Recruitment is working with the Superintendent of Nurses at the Washington County Hospital. A pamphlet entitled "Nursing—Is It Your Career?" has been placed in all the Junior and Senior High Schools, where we shall from time to time place further information. A tea and a tour of the hospital has been given, and two more are planned for girls interested in nursing as a career. At our April meeting we voted to establish a nursing scholarship, the full cost of which will be underwritten by our members.

Our program has included an October joint dinner meeting with Frederick County, at which the election of officers was held.

In a January Tea meeting at the Art Museum, we

installed the new officers and discussed Nurse Recruitment and our March Safety Drive.

In April we had a dinner meeting at the Hotel Alexander on Civil Defense, with movies and a lecture on atomic bomb defense by Dr. Ernest F. Poole, Deputy Director of the Medical Service, Washington County Civil Defense. There was also discussion of a Nurses' Day Tea for prospective nurses, and announcements of the state meeting.

Since we are a rather new group, we have only just reached the point at which a Ways and Means Committee is necessary. Our nursing scholarship will require us to raise \$710.00 within the next three months. Therefore, we are at present earnestly studying various methods of raising money.

PROGRAM PLANNING

The Woman's Auxiliary to the Medical and Chirurgical Faculty will appreciate very much any invitations from our Component Auxiliaries to the State President, Mrs. Charles H. Williams, to attend one of their meetings next fall or winter. Whether Mrs. Williams actually participates in the program is not as important to us as the maintenance of personal contact. Such contact accomplishes much more than is possible through correspondence and thereby benefits the State as well as the Component Auxiliaries.

LEGISLATIVE LIGHTS

MRS. H. HANFORD HOPKINS

The following are just a few of the very numerous Bills on Health Legislation which are pending: S 2705, which would amend the Social Security laws and provide permanent and total disability insurance and rehabilitation benefits. H.R. 6215, for rehabilitation of the handicapped. H.R. 6720, to provide Federal Aid to States for school programs of health instruction and physical education. S 445 for "Aid" to local public health units. H.R. 7484, which amends Federal Old Age and Survivors Insurance system to provide aged persons and also the *dependents* and *survivors* of the deceased insured persons, with insurance against the cost of hospitalization.

News releases from the Federal Security Administration itself, however, have stated that "A greater proportion of births in the United States were delivered in Hospitals and Institutions in 1947 than

in any previous year on record." Maternal Mortality decreased to a new low. "Infant mortality in 1947 was the lowest on record." "Length of life is nearly two years above the level reached before World War II—and finally, the death rate in 1948 was the lowest in the history of the country."

In presenting these Health Bills which are pending, compare them with the quoted Federal Security Administration news release and ask yourself if it makes for logic to exchange our present admittedly successful health system for another which is experimental and dangerous? Are we satisfied with this piecemeal socialization of medicine which is pending and may be gradually enacted? We must be, or more of us would write to our Congressmen, talk to our friends and get out and vote!

AUXILIARY NEWS

The Nursing Committee of the Woman's Auxiliary to the Medical and Chirurgical Faculty thoroughly enjoyed meeting the representatives of the Nursing Profession who attended our Nurses' Day Tea, on May 12th, Florence Nightingale's Birthday. The Tea was held at the Medical and Chirurgical Faculty Building, and we are especially indebted to the Component Presidents such as Mrs. S. Robert Wells, of Hagerstown, for instance, who came by *bus* and brought the Washington County Auxiliary's scholarship student nurse with her. Component Presidents acted as Hostesses and it was most exciting to talk to our own "scholarship" girls. We also were proud to learn that among our distinguished guests were the Deans and Directors of Nursing Schools, Presidents of Nursing Associations, etc., and several doctors' wives.

Our "Famous Family," the E. Paul Knotts, can boast of Dr. Knotts, "Family Doctor of the Year," Mrs. Knotts, Doctor's Day Chairman, who secured the Governor's Proclamation of Doctor's Day for us, and a gifted daughter, Elizabeth Knotts Davison, whose paintings added so much to our Creative Arts Show!

The wonderful news that the daughter of Dr. and Mrs. Jack H. Beachley, of Hagerstown, will marry the son of Dr. and Mrs. S. Robert Wells, seems to carry out the Auxiliary purpose of "promoting friendship among physicians' families" thoroughly. Our very best wishes!

Mrs. Martin Strobel, President of the Woman's

Auxiliary to the Baltimore County Medical Association has been appointed to the Board of Directors of the Baltimore County Public Health Association. Also, Mrs. George H. Yeager, Auxiliary News Editor, is now on the Board of the Maryland Society for Medical Research.

We think that the Chairman of our Creative Arts Show, Mrs. Beverley C. Compton should be congratulated upon her own paintings, as well as on her successful management of that fine exhibition.

CAMPAIGN POINTERS

The fact that Governor Warren of California has been proposed as a running mate for General Eisenhower should give us caution. Warren is an outspoken proponent of socialized medicine. As Auxiliary members we ought not to vote without finding out, from past performance rather than from vague promises, where a man stands in regard to integrity and the will to fight for the right rather than to just "go along" pleasantly, whether he puts America's interests first or last, and where he stands on domestic issues such as socialized medicine, socialized housing, and socialized education, which are designed to change our form of government.

ARE YOU REGISTERED TO VOTE?

MRS. A. S. CHALFANT

Citizens who are displeased with the manner in which our Country's affairs have been conducted in

the last four years have only themselves to blame if they have not voted regularly. If these people, who are eligible to vote, care so little about their right to self-government as free citizens, then the governing will be done by power hungry men who believe that they know better what is good for us than we do ourselves.

The percentage of those citizens eligible to vote in this country who actually did vote in the last Presidential Election was appallingly low! Proportionately, nearly twice as many people voted in Italy in their big election. The Italians defeated Communism and prevented their country from losing its freedom. As a result of our indifference, we have witnessed, here in America, a "creeping Socialism" which if continued would inevitably lead us to a Totalitarian Socialist state.

History must *not* be allowed to repeat itself this November! We must know where the candidates stand on vital issues and we must vote. We must influence our families, our friends, and our neighbors to register and to vote.

In Baltimore, July 14th is the only day for local precinct registering. *However, you may register at the Court House until six weeks before the November election.* The Office of the Supervisor of Elections is open from 9:00 A. M. to 3:00 P. M., Monday through Friday, and from 9:00 A. M. to noon on Saturday.

In the Counties, The Court House at the County Seat is the place to register.

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SENATE COMMITTEE INCREASES PHS APPROPRIATION BY ALMOST \$4.5 MILLION

Capitol Clinic, A. M. A., Vol. 3, No. 17, April 29, 1952

In reporting out the Public Health Service Appropriation bill for next fiscal year, Senate Appropriations Committee increased the total \$4,462,000 over that recommended by the House. Some of the substantial increases include: *National Cancer Institute*, \$14.3 million allowed by Senate Committee, or \$2.6 more than House figure; *Mental Health Activities*, \$10.7 million or an increase of \$194,000 over House figure; *National Heart Institute*, \$12 million, or \$2.4 million increase over House figure. The Senate Committee cut PHS funds for general assistance to states to \$15.1 million, a reduction of \$220,000 under the House figure. The Senate Committee accepted the House figure of \$75 million in new funds for the *Hill-Burton* hospital construction program. After passage of this bill by the Senate, final figures will have to be worked out in a Senate-House conference committee.

Ancillary News

DENTAL SECTION

BALTIMORE CITY DENTAL SOCIETY

A. BERNARD ESKOW, D.D.S.

On April 14, 1952, the Baltimore City Dental Society had as its guest essayist Dr. Maury Massler, Professor and Head of Department of Pedodontics in the College of Dentistry and Lecturer in Stomatology and Oral Medicine in the College of Medicine, University of Illinois. His subject was "Management of Oral Habits in Children". His presentation was most informative and very well received.

The May meeting of the Baltimore City Dental Society was its annual business meeting. It was preceded by a dinner at the Sheraton Belvedere Hotel in honor of our retiring president, Dr. Paul

Deems. The Executive Council noted the occasion by presenting Dr. Deems with an engraved silver dish as a token of their esteem and regard for his services to the Society. The election of officers which then took place at the Medical and Chirurgical Building were as follows:

Dr. Arthur S. Wheeler, *President*; Dr. William Kress, *President-Elect*; Dr. Carl Schultheis, *Secretary*; Dr. E. D. Lyon, *Treasurer*; Dr. I. Abramson, Dr. R. J. King, Dr. Filbert Moore, *Executive Council* (3 years).

Dr. Deems presented the incoming President, Dr. Wheeler, with the president's gavel. The new officers were introduced to the society and the meeting adjourned.

PHARMACY SECTION

MARYLAND BOARD OF PHARMACY

L. M. KANTNER, PHAR. D., *Secretary*

On April 26, last, a law became effective, the provisions of which regulate the filling and refilling of prescriptions to a greater extent than any legislation since the enactment of the Harrison Narcotic Act.

This law, known as the Durham-Humphrey Act, places drugs into two categories—namely, those that can be sold without a prescription and those that can be dispensed only on a prescription.

The law reads in part thus: "A drug intended for use by man which because of its toxicity or other potentiality for harmful effect, or the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug."

Manufacturers must include in the labeling of such drug: "Caution: Federal Law prohibits dispensing without prescription."

The purpose of this law is very understandably stated in the section quoted.

The law further states that such drugs shall only be dispensed: (1) upon the written prescription of a practitioner licensed by law to administer such drugs; (2) upon the oral prescription of such practitioner; or, (3) by refilling such written or oral prescription if such refilling is authorized by the prescriber either in the original prescription or by oral order.

The act of dispensing a drug that requires a prescription for dispensing will constitute an act which results in the drug being misbranded while held for sale. Pharmacists are experiencing a hostile reaction from some of their patrons when they inform them that the prescription they have been having refilled repeatedly can no longer be refilled without the prescriber's order. Reports are being received that when pharmacists contact physicians relative to again refilling a prescription, the physician often states: "I have not seen that patient for one to four years." In such cases the question can be asked:

"Is not such a person practicing self-medication, and possibly aggravating conditions, with a drug that is potentially dangerous?"

The Food and Drug Administration takes the attitude that a physician prescribes a drug for a definite physical condition at a particular time. The patient may diagnose what to him seems a similar condition at a period from one to four years after the drug was originally prescribed, and may be using such a drug with damaging effect.

Drugs that can be dispensed without a prescription but are often prescribed by physicians can be refilled without the prescriber's authorization.

There may be patients who are required to take a particular medication practically all their lives, but these are rather exceptional. The physician has several courses to follow in writing prescriptions. If he desires the patient to continue with the prescribed medication for a definite period, he can indicate on the original prescription to refill for the length of time considered advisable. If this course is not followed and the patient requests the refilling of the

prescription, the only course left to the pharmacist is to obtain the prescriber's authorization.

Under regulations, the physician's nurse or secretary can orally convey the prescriber's order to refill a prescription, but under no circumstances can a patient convey the authorization.

There are records where a patient has obtained as many as 7,000 tablets by repeatedly having a prescription refilled that called for only 20 tablets, and investigation disclosed 20 and no more of the tablets were all the physician wanted the patient to have. Such disclosures usually come to light after a tragic experience.

Therefore, it is suggested that physicians include on their prescriptions directions not to refill (N.R.); to refill a definite number of times; or use the term P.R.N. If this term is used it should be emphasized as "Refill P.R.N." and not just "P.R.N.," because the administration holds that "P.R.N." is a term used in directions and does not apply to refilling the prescription where requested.

There is nothing in this act that in any way alters the provisions of the Harrison Narcotic Act.

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Administrator*

Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations

WORKING CONFERENCES: ANALYSIS OF ACTIVITIES OF THE HEAD NURSE

Five two-and-one-half-day working conferences on an analysis of the activities of the head nurse have been cooperatively sponsored by the National Committee for the Improvement of Nursing Services, the American Hospital Association and the United States Public Health Service. The conferences were held in Cleveland, St. Louis, New Orleans and Salt Lake City in April, and in Washington, D. C. in May.

Since the head nurse is the key person in providing nursing care for the patient, she is considered of major importance in any program for the improvement of nursing services.

The method of analysis has been designed by the Division of Nursing Resources of the United States

Public Health Service and the working conference instruction has been provided by the USPHS. Those eligible to attend were persons who will direct head nurse studies in their own hospitals, state hospital nursing consultants, and faculty members from universities conducting programs in nursing service administration. The last two categories must be willing to teach others the method of study taught at the conferences.

In the November 1951 issue of *Modern Hospital* an article by Ruth Gillan of the USPHS reported on an analysis of head nurse activities in one hospital. Since this article appeared, the NCINS has received inquiries from nursing service administrators interested in making similar analyses. It was at the request of the NCINS that the USPHS agreed to provide instruction for this series of working conferences.

Maryland nurses who attended the Washington Conference held May 5-6-7 are: Barbara S. Howell, Chairman, Joint Committee for the Improvement of Nursing Services of the Joint Board of Directors of the Three Maryland State Nursing Organizations; Marguerite E. Hydorn, Supervisor, University Hospital; Ruth Preston, Supervisor and Instructor Medical Nursing, The Johns Hopkins Hospital; Sarah I. Wharton, Assistant Director, Clinical Instructor, in charge of Out-Patient Department, Church Home and Hospital, and Miriam A. Moellman, Head Nurse, Church Home and Hospital.

On May 19 and 20 a two-day working conference

on Head Nurse Study Methods was held at the Johns Hopkins Hospital under the auspices of the Joint Committee for the Improvement of Nursing Services of the Joint Board of Directors of the Three Maryland State Nursing Organizations. Participants in instruction for this conference were those Maryland nurses who attended the Washington Conference. Attendance at the conference in Baltimore was limited to persons chosen by directors of nurses to direct head nurse studies in their own hospitals. Those participating in the conference were pleased to see how well nurses who attended the Washington Conference were able to teach others.

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WAR MANPOWER COUNCIL URGES MILITARY DEFERMENT THROUGH ONE YEAR OF RESIDENCY

Capitol Clinic, A. M. A., Vol. 3, No. 15, April 15, 1952

The War Manpower Council, a citizens' organization financed by the Ford Foundation, has recommended that physicians be deferred from military service until completion of one year of residency training. The Council's report, *Student Deferment and National Policy*, lists this among its 14 recommendations made to Defense Department, Selective Service and other government agencies.

Currently, medical students are deferred through one year of internship, by which time they are subject to the Doctor-Draft law.

Letters to the Editor

Dr. Ralph W. Ballin, Captain in the Medical Corps, writes the following:

"I want to thank you very much for putting me on the mailing list of our new State Medical Journal. By now I have received two copies, and, being away from home, it is doubly satisfying to see all those familiar names and to be able to keep in touch with what is going on.

"The paper on the panel discussion on peptic ulcer was particularly enjoyable and it certainly proves that a medical journal can be written in such a fashion as to make it readable. I am sure that all of us can be proud of the new journal which is likely to take its place with the best of them."

* * *

Dr. W. W. Francis, the nephew of Sir William Osler and Librarian of the Osler Library, McGill

* * * * *

University, Montreal, is a friend of Dr. Chatard's, and upon receipt of the first Maryland State Medical Journal, wrote a letter to Dr. Chatard. The following is quoted:

"That looks like an A-1 State Journal. Congratulations all round on it. Thanks for sending me No. 1. It has dignity and interest and should prosper, realize all your hopes for it, and Osler-wise rejuvenate the venerable, but evidently far from senile, Faculty.

"I'm glad to see that Aesculapius has revised Homer's spelling in the seal. That motto is one of the first and greatest compliments ever paid the profession, and deserved to be letter perfect.

"Floreat Soc. Med. & Chirurg. Terrae Mariae."

* * *

MARYLAND SOCIETY OF PATHOLOGISTS

CLINICAL PATHOLOGY IN MARYLAND

HENRY L. WOLLENWEBER, M.D.*

It has been called to our attention that physicians are not aware of the existing facilities for taking care of laboratory needs in their own communities. Free pathologic service has been rendered by the over-burdened State Department of Health and American Cancer Society to meet the apparent need in spite of the fact that care of indigent patients only was intended. Because of the lack of publicity, the Maryland Society of Pathologists was requested to submit a list of local pathologists available for cytologic, biopsy and other laboratory studies. These physicians have agreed to perform laboratory

services in accordance with ethical standards of medical professions:

BALTIMORE CITY

H. Beisinger, M.D.	Woman's Hospital, Baltimore, Md.
F. H. Foucar, M.D.	Maryland General Hospital
W. C. Merkel, M.D.	Union Memorial Hospital
V. H. Norwood, M.D.	Church Home and Hospital
	St. Joseph's Hospital
D. L. Reimann, M.D.	University Hospital
C. W. Stewart, M.D.	6 East Read Street
J. A. Wagner, M.D.	Lutheran Hospital
	St. Agnes Hospital
T. A. Weinberg, M.D.	Sinai Hospital
H. L. Wollenweber, M.D.	225 Medical Arts Bldg.
R. B. Wright, M.D.	Franklin Square Hospital

* Executive Secretary, Maryland Society of Pathologists.

COUNTIES OF MARYLAND

Allegeny County	B. Skitarelic, M.D. Memorial Hospital, Cumberland, Md.	Garrett County	Frederick Hospital Frederick, Md. B. Skitarelic, M.D. Memorial Hospital Cumberland, Md.
Anne Arundel County	George Carroll, M.D. Anne Arundel General Hospital Annapolis, Maryland	Harford County	H. L. Wollenweber, M.D. Harford Memorial Hospital Havre de Grace, Md.
Baltimore County WEST	See Baltimore City List H. L. Wollenweber, M.D. Branch Laboratory Abbott Medical Center 4509 Liberty Heights Avenue Baltimore 7, Md.	Howard County UPPER	J. A. Wagner, M.D. St. Agnes Hospital Baltimore, Md.
EAST	H. L. Wollenweber, M.D. Branch Laboratory Rosedale Medical Group 8019 Philadelphia Road Baltimore 6, Md.	LOWER	O. B. Hunter, M.D. Montgomery County Gen. Hosp. Sandy Spring, Md.
Calvert County	Cliff Berger, M.D. Sibley Memorial Hospital Washington, D. C.	Kent County	K. E. McCullough, M.D. Peninsula General Hospital Salisbury, Md.
Caroline County	K. E. McCullough Peninsula General Hospital Salisbury, Md.	Montgomery County	J. E. Ash, M.D. Suburban Hospital Montgomery County, Md.
Carroll County	Henry A. Stewart, M.D. Gettysburg Hospital Gettysburg, Pa. F. H. Foucar, M.D. Maryland General Hospital Baltimore, Md.	Prince Georges County	Wm. C. Manion, M.D. 5353 Quincy Place Bladensburg, Md.
Cecil County	H. L. Wollenweber, M.D. Union Hospital Elkton, Md.	St. Mary's County	H. H. Leffler, M.D. Jarwood Clinic Waldorf, Md.
Charles County	H. H. Leffler, M.D. Providence Hospital Washington, D. C.	Somerset County	K. E. McCullough, M.D.
Dorchester County	K. E. McCullough, M.D. Peninsula General Hospital Salisbury, Md.	Talbott County	Peninsula General Hospital
Frederick County	J. O. Collins, M.D.	Wicomico County	Salisbury, Md.
		Worcester County	
		Washington County	Paul Butterfield, M.D. Washington County Hospital Hagerstown, Md.

Pathologists serving Maryland, whose names may have been inadvertently omitted from this list and who desire to be included, should contact the Maryland Society of Pathologists, 225 Medical Arts Bldg., Baltimore 1, Md.

SEMIANNUAL MEETING

Commander Hotel, Headquarters

Ocean City, Maryland

Friday, September 12, 1952

During the month of AUGUST the office and library will be open until 4 p.m. instead of 2 p.m. as has been our custom heretofore.

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 1

August, 1952

NUMBER 8

EDITORIAL

TRANSACTIONS

GEORGE H. YEAGER, M.D.*

Medical society meetings are well worth attending! They help to make one study and think,—two things which every physician should do, but which in the whirl of a busy life he is sometimes prone to forget.

In addition, they jog him out of an old rut in which he is too likely to travel. They help to tighten the bond of friendship between himself and his colleagues. These are consummations greatly to be desired, and most unreasonable is the doctor who is unwilling to acknowledge this fact. Personal grievances, which occasionally keep a physician away from a society to which he should belong, are as a rule largely imaginary, and always wholly unjustifiable. The faultfinder, who “does not like the way in which the thing is run,” should go and help to run it.

Medical societies are democratic organizations, in which every medical man and woman has an equal chance, and no one of them has a moral right to stay at home and be a growler.

This issue of the Maryland State Medical Journal contains part of the Transactions of the Annual Meeting of the Medical and Chirurgical Faculty, held in April 1952. The September and October issues will also contain the 1952 Transactions. The Annual Meeting Program was published in the Maryland State Medical Journal, Vol. 1, No. 3, March 1952. This issue also contained the names of the officers of the Faculty and Component Medical Societies.

The last printing of the Transactions was in 1938, and so far as the Editor can ascertain, this is the first time for many many years that the Transactions have been mailed to each member of the Medical and Chirurgical Faculty. It represents an availability of information to every member of this Society. Perusal of committee reports, House of Delegates and Council actions should prove worthwhile.

You should acquaint yourself with your Society and learn of its constant daily functions and responsibilities. Start now, and advantageously become acquainted with your Medical Association. Then start to demonstrate an active interest in its affairs.

* Editor, Maryland State Medical Journal; Secretary, Medical and Chirurgical Faculty of the State of Maryland.

TRANSACTIONS

One Hundred Fifty-Fourth Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY
of the State of Maryland

1211 Cathedral Street, Baltimore, Maryland

SCIENTIFIC SESSIONS

Tuesday and Wednesday, April 29, and 30, 1952

BUSINESS SESSIONS

April 28, 29, 30, 1952

Part I

Pages 369-425

Scientific Sessions

*Medical Education and Medical Research are Part and Parcel of the Medical Profession**

ALAN M. CHESNEY, M.D.

One of the penalties which those who attend this particular session of the annual meeting of the Faculty have to pay, is to listen to an address by the presiding officer. There seems to be no escape from this ordeal which is ordered by our constitution, save by avoiding coming to this session altogether. Since you have all had fair warning of what is in store for you, however, through the publication in advance of a brief synopsis of these remarks, you have only yourselves to blame if you have not heeded the warning and availed yourselves of your inalienable right to remain away from this session altogether, and seek entertainment before some handy television set.

I would not have you infer from what I have just said, however, that I think for one minute that those of you who have turned out this evening have come here for the purpose of hearing what *I* have to say. I really am not that naive, I assure you. I know very well that you have come to hear what our distinguished guest is going to tell us about one of the most important medical topics of the day, but I have a duty to perform and I fear that you will have to wait until that duty is discharged before you can hear from him.

Before taking up the main theme of my remarks I must first tell you how deeply grateful I am to you members of the Faculty for the

great honor which you have bestowed upon me in electing me to the highest office in the gift of this body. I do this in spite of the fact that I realize fully that you had no real opportunity to vote on any other name and that you were completely at the mercy of a nominating committee which probably met at the end of a long and trying day, when imagination and capacity for sustained thought are not usually at their best!

However that may be, I do wish to assure you of my everlasting gratitude and deep appreciation for the honor which you have done me. No greater one can I hope to attain in the remaining years of my life, and no greater do I crave.

My appreciation is all the more keen because my life has not been spent in the hurly burly of the active practice of medicine, as has been the case with so many of you, but, on the contrary, has been spent in full-time teaching, research and, more recently, administration, all within what some of you, I am certain, regard as cloistered walls. Let me hasten to assure you, however, that the particular cloisters within which I have had occasion to spend my working hours these last thirty years are not by any means always without some hurly burly and even, dare I whisper it, occasional strife!

Whatever may have been the reason that led to the nominating committee's selection, I have elected to draw one conclusion from its act and that conclusion is that underneath the

* Presidential Address, Annual Meeting, Medical and Chirurgical Faculty of Maryland, Baltimore, Maryland, Tuesday evening, April 29, 1952.

decision of the committee in this instance lay a realization, perhaps even subconscious, that the medical profession is not limited solely to those physicians who are engaged in the active practice of medicine, but also should be considered to include those physicians who devote their entire time to medical teaching, to medical research, and even (God save the mark!) to medical administration, including of course those physicians who deal with the public health; and further, that at least once in a while it would seem fitting to recognize this particular group of workers in the medical vineyard by electing one of their number to an office in the Faculty.

Whether or not I am correct in the conclusion which I have just stated, I am prepared to assert one principle and that is that medical education and medical research are part and parcel of the profession of medicine and must be taken into account in the consideration of any wide-ranging proposals that affect the profession.

Whether we men and women who hold the degree of doctor of medicine are active practitioners, full-time teachers, investigators, or administrators, we have one great thing in common, a single objective which unites us all, and that is the welfare of the patient and not the welfare of ourselves. That is our common bond. We differ from one another only in the particular task which we have elected to perform in the pursuit of our common objective, but that is the only difference between us and, save to the individual himself, it is of no real significance. We are, to borrow a phrase from Shakespeare, a "band of brothers," and we seek no partisan advantage over one another.

If this contention of mine *is* correct, if we *are* in truth associates in a common enterprise no matter what our contributory skills may be, then it behooves all of us to see to it that each understands the other's special problems and needs, and that no one of us takes action that will embarrass or adversely affect the other in his pursuit of our common objective.

Because I am so firmly convinced that these concepts are true, I consider myself justified in laying before you this evening some of the problems that confront medical education and medical research in our country today. You cannot fail to be interested in these problems for upon their successful solution depends not only the future of the medical profession itself, but also the health and welfare of the entire nation.

These twin activities, medical education and medical research, are bound so closely to one another that it seems almost absurd to list them as separate activities. I doubt if there is a single medical school in the country today in which the members of the faculty devote their entire time to teaching and do not carry on any investigations of their own. If there *is* such a school, I would think it scarcely worth its salt. Nevertheless, for the sake of convenience, I shall have to discuss these two activities separately but please bear in mind that to all intents and purposes I consider them as one.

Medical education in the United States at the present time is at the highest peak it has ever attained, either in this country or anywhere else. Not even German medical education of the latter half of the nineteenth century, which certainly excelled that of any other country during that particular period of history, can be said to equal American medical education of today. And yet our system of medical education, superior as it is, is in real jeopardy, in my opinion, for reasons for which the medical schools themselves are certainly not to blame.

The difficulties which confront the medical schools nowadays are two-fold. They are, first, insufficient money with which to continue to operate at the level of excellence to which they have already attained and at which they should be maintained in the interest of the public, and, secondly, shrinking clinical material for training purposes, particularly for training beyond the M.D. degree. I shall deal with these two serious difficulties in the order in which I have listed them.

The medical schools are in financial difficulty today because they have suddenly been faced with sharp increases in the cost of their normal operations without being able to increase their income proportionately. The problem of financing medical education is but one phase of the larger problem of financing graduate and professional education in general, but it is the largest phase of that whole problem because it has become such an expensive form of education.

There is not time this evening to go into all of the reasons why medical education is so expensive but I wish to mention two factors that make it so and are by no means unimportant. The first is that the medical schools, like many other civilian enterprises, are in keen competition with their own government in the matter of providing salaries for technicians, secretaries, clerks and even faculty personnel. The second is the fact that medicine now embraces within its broad confines many scientific disciplines whose body of knowledge is such that they deserve to be considered as separate sciences, worthy of study in their own right, and not merely as handmaidens to clinical medicine. Thus the medical school of today will have a dozen different departments which must be staffed and supported if the students are to have the best type of medical instruction, and it takes money to keep those departments going on a basis that will continue to attract good men and women as faculty members.

I do not believe that the cost of medical education is going to diminish in the foreseeable future, unless the economic circumstances of the country change very markedly, but I wish to raise this question—do we really want the cost to diminish? After all, it is chiefly in the medical schools that man as a living organism is being studied, and are not all of us more concerned with man than with any other form of life? Alexander Pope has said that the proper study of mankind is man himself. Surely there is no place where the study of man as a living thing reaches the height,

the breadth and the intensity that it does in our medical schools of today.

There are those who say that the medical schools should economize. I will grant that they can decrease their expenditures but at what and at whose cost? In the end the cost of such a reduction would be borne by the people themselves in terms of a lower quality of medical care in my opinion. Is that what the people of America want? I doubt it.

How can we solve this financial problem of the medical schools? Let me say at the outset that there is no single pat solution for the difficulty, in my opinion, but let us first have a look at where medical school money comes from.

The main possible sources of income of the medical schools are five in number: (1) tuition fees, (2) income on endowments, (3) gifts for current operations, (4) fees for professional services rendered by full-time faculty members, and (5) subsidy by government, whether city, state or federal. Let us consider these sources for a moment.

With reference to tuition fees, the time has long since gone by when it was possible to finance medical schools on the basis of fees from students, and it is fortunate for the public that such is the case. Medical schools in America used to be good businesses in the last century and even yielded profits to their owners and faculties but that is no longer true. Deficits, not profits, are the rule nowadays. I should be sorry to see the level of tuition fees in the privately owned medical schools raised much higher than it is today. Not only do we not wish to price ourselves out of the market; more important, we do not want to exclude from our schools gifted young men and women who lack the means to pay for a medical education. It is abundantly clear, therefore, that tuition fees can no longer be counted on to balance the medical schools' budgets.

As for income on endowments, everybody knows that not only is the yield on invested capital less than it was in the past but also that through increased taxation the opportunity to

build up capital to disburse for philanthropic purposes is far smaller in the United States today than it was during the last century when the country's great resources were just being opened up and there was no such thing as an income tax. I do not believe that the gap will be bridged through increased endowments for the medical schools, much as I should like to think that it would.

The case for bridging the gap through the use of gifts for current operations looks better for the time being. An earnest and sustained effort is being made on a nation-wide basis to obtain such gifts through the establishment of a fund called the National Fund for Medical Education, Incorporated, whose purpose it is to secure unrestricted funds to be used for the general operating expenses of the medical schools. The American Medical Association through its offspring, the American Medical Education Foundation, has already made two contributions of a half a million dollars each to this Fund, and the Fund has in turn made two cash distributions to the schools. I doubt not that some of you in this audience have by your own individual gifts through the American Medical Association made these donations possible and if that is the case I can assure you that the two medical schools of Baltimore greatly appreciate your generosity. Industry is being approached to contribute to this National Fund and it remains to be seen what the response will be. I might add that industry itself owes much to medicine and here is the opportunity for it to repay its debt.

Those medical schools whose clinical departments are organized on the full-time basis have the opportunity to utilize as income for their day-to-day operations, the fees collected from patients for professional services rendered by the full-time members of the clinical staff. The part played by income from this source in the total operating income of a given school will depend upon a number of different factors such as the size of the full-time staff, the extent to which the full-time members of the staff are in

competition with part-time members of the same staff in the same hospital or in the community at large, the extent to which the full-time staff members want to spend their time in taking care of patients, and the way in which the fees themselves are utilized in meeting the expenses of the institution. Because of all these variables, which may themselves change from year to year, it is hazardous for a school to rely too heavily upon the professional earnings of its full-time faculty to eke out its budget. Private patient fees have a way of diminishing very rapidly when times are not so good, as I daresay many of you know all too well!

It should be pointed out in this connection that the medical schools by and large contribute a great deal of professional service to the communities in which they are located through assisting in the care of patients who cannot afford to pay for all of the cost of such care. For this contribution the schools have not, in general, been adequately reimbursed by the communities so served. Per diem allowances to hospitals by city or state or both, for the care of the indigent or medically indigent, have not thus far carried any sums for reimbursing the medical schools for their contribution to this care, so far as I am aware, but the matter is one that deserves very careful study and an appraisal, if possible.

I come finally to government subsidy and here I touch a thorny question. There are 72 approved four-year medical schools in the country today. Three are parts of municipally-owned universities, 29 are parts of state-owned universities, the remaining 40 are privately owned. These last have a little over half of all the medical students enrolled at any one time in the country as a whole.

Those schools which are owned by either cities or states and subsist on legislative appropriations as well as tuition fees are already taking city or state money as the case may be, since none of them can possibly subsist on tuition fees alone. There has been no outcry against these schools taking *more* money from their owner-govern-

ments, so far as I am aware, not even from the bitterest opponents of federal subsidy of anything. The real controversy, therefore, revolves around the question,—should the medical schools, be they city-owned, state-owned, or privately owned, accept any money whatsoever from the Federal Government for their day-to-day operations, no matter whether there are strings attached to this money or not?

The individual's answer to that question will probably vary depending upon his own political philosophy. Some persons will unhesitatingly say "no." Some will say "yes, it is alright, if there are no restrictions." Others will say that it depends upon the character of the restrictions. I have no right to speak for any medical school other than the one with which I have the honor to be connected, but I say unhesitatingly that I do not believe that any of the medical schools of the country would accept any subsidy from the Federal Government whatsoever if that subsidy carried with it any restrictions in regard to the choice of faculty, selection of students, subjects to be taught or problems to be investigated.

Freedom to choose the faculty, freedom to select the student-body, freedom to determine what shall be taught and how, and finally freedom to investigate those problems that attract our interest,—these are the four freedoms that we of the medical faculties, in common with our colleagues in all the other university faculties of the country, claim as our birthright. Will we of the medical schools sell any one of these freedoms in return for Federal subsidy? Certainly not!

But, to be perfectly honest in this matter, we must ask ourselves the question,—is there any real danger that the Federal Government will attempt to impose stultifying restrictions upon the medical schools in return for a subsidy for day to day operations? The only answer that I can give to that question is that since the close of the war the Federal Government has given large sums of money to the medical schools for

research, for the improvement of teaching in the field of cancer and of heart disease, for training in psychiatry, and for the construction of facilities for the investigation of heart disease and of cancer, without laying down any restrictions which would at all interfere with the freedom of the medical faculties that accepted this money. And may I, in passing, call your attention to the fact that this alleged danger of interference is not limited to the Federal government? At least one state legislature has passed a law prohibiting its own medical school from admitting residents from other states. This is interference almost at its worst.

My own feeling is that the medical schools can be trusted not to take Federal money without proper safeguards. I imagine that many of us in the medical faculties, and particularly those of us who have to administer the budgets, would be only too happy if we didn't ever have to ask anybody for money. But we cannot be expected to maintain high standards and let our institutions go bankrupt in so doing, and at the same time refuse Federal money that comes to us without stultifying restrictions just because it is Federal money. When states in which medical schools are located no longer apply for Federal funds to build their hospitals and roads, and to finance their welfare and public health programs, it will be time enough, it seems to me, to expect the medical schools in those same states not to accept Federal funds.

We of the medical schools want this question of Federal assistance to medical education debated on its merits alone and not allowed to become a football of partisan politics. We particularly do not want it to be tied up with legislation providing for national compulsory health insurance, otherwise known as "socialized medicine," with which it has no connection whatsoever and with which it should not be allowed to have any connection. Indeed, if legislation to provide Federal aid to medical education is tied up with legislation to provide national compulsory health insurance I would hope that the

medical schools would individually and collectively throw their entire weight against such legislation.

During the 81st Congress companion bills (S. 1453 and H.R. 5940) designed to provide emergency Federal aid to medical, dental, public health and nursing education, were introduced into the Senate and the House of Representatives. The Senate bill passed but the House bill did not. These two bills were opposed by the American Medical Association largely but not exclusively on the ground that the freedom of the medical schools was not sufficiently protected.

Similar bills (S. 337 and H.R. 2707) were introduced into the present (82nd) Congress last year. They too have been opposed by the American Medical Association. The House of Delegates of that body at the Atlantic City meeting in June 1951 approved the following statement of policy:

"The policy of the American Medical Association shall be the endorsement of the principle of a one-time federal grant-in-aid on a matching basis, based on the Hill-Burton Act formula, and administrative machinery, for construction, equipment and renovation of the physical plants of medical schools. No part of the funds shall be used in any manner for operational expenses or salaries."

The Baltimore City Medical Society has also gone on record during the past year as opposing the Senate bill.

The Association of American Medical Colleges, after polling all its member medical schools, supported the Senate bill in its original form but opposed an amendment which was offered later on, known as the Pastore amendment, which would have constituted what Dean Berry of the Harvard Medical School has called "a seductive stimulus to over expansion" by the schools. That amendment was voted down but the bill has not been called up for a vote in the Senate and probably will not be called up during the present Congress.

It is clear from what I have just related to you that there is a division of opinion in medical circles concerning this particular piece of legislation. However, I would call your attention to the fact that the American Medical Association has never at any time taken the position that it opposes Federal aid to medical education under any and all circumstances. But let us suppose that it should come out with such a statement. This Faculty does not have to agree. We are under no compulsion whatever to accept the Association's viewpoint if we do not choose to do so. While this state association of ours is a constituent member of the American Medical Association with the right of representation in that body, nevertheless in accepting that status the Faculty did not cede a single right to the national body as did our own sovereign state of Maryland when it united with the other independent states to form the United States of America. Indeed, in this respect we are freer than our own state and I think that it would be entirely in accord with the facts, therefore, if we changed the name of our society from the Medical and Chirurgical Faculty of the State of Maryland to the "Free Medical and Chirurgical Faculty of the Somewhat-Less-Free State of Maryland," although I have no intention of making such a proposal I assure you!

At this point I should like to summarize my own views in regard to federal aid to medical education in order that there may be no misunderstanding. I would prefer to see the medical schools get along without federal aid if they can do so without lowering their standards or going bankrupt. If such aid carries with it restrictions which compromise the independence of the schools it should be refused altogether. If there are no compromising restrictions it should be accepted rather than that the schools should lower their standards or go under. In my opinion the schools themselves are capable of judging whether or not their liberties would be restricted by any particular piece of legislation, and can be trusted to safeguard their own interests. City,

state and national medical associations would do well to consult fully and freely with the medical schools in reference to any particular piece of legislation involving Federal aid to medical education before expressing an opinion one way or the other in regard to such legislation. This has not been done in every instance, I regret to say. Whether or not the schools will have to accept Federal aid will depend in the end upon the support the people of this country are willing to give them on a voluntary basis.

Thus far I have been speaking of the medical schools principally as teaching and training institutions. It is now time for me to deal with them as agencies for the discovery of new knowledge.

The development of our medical schools as institutions for the advancement of knowledge since the turn of the century is one of the most striking phenomena in the educational development of our country. Save for perhaps a half dozen only, the medical schools of the United States in 1900 were totally devoid of research activities. Now there is probably not one in which some research is not carried on and in some schools the volume of research activity is truly enormous. Moreover much of this research is of high quality and it certainly paid off during the last war.

The American people have become research-conscious to a degree, and have given liberally to support it through the drives to raise money to combat this and that disease. Moreover the large philanthropic foundations have been generous in their support of it and succeeding Congresses since the last war have appropriated large sums for medical research, but the flaw in this beautiful golden horn of plenty is that most of the money which has been made available has been limited to special fields and even to special restricted projects, and is not available to help the schools in their ordinary day-to-day operations to any real extent.

The medical schools are in the paradoxical position where they have on the one hand too little unrestricted money for their normal day-

to-day business of teaching medical students, training teachers and investigators, and caring for patients, and, on the other hand, almost too much for carrying out special research projects. This is not a healthy situation. To begin with, if we wish research to attain its highest level of quality, and quality is what counts in research more than in any other human endeavor perhaps, we must allow the investigator full play for the development of his imagination and his intellect, and we must encourage him to pursue his ideas wherever they lead him. Then and only then will we have the great fundamental discoveries that underlie all our day to day practice and enable us to take advantage of the great riches which nature holds for us.

Moreover research comes only from prepared and trained minds, and, in the medical field, we must continue to look to trained men and women who hold the M.D. degree to carry on a large if not the lion's share of medical research. With all due respect to the physicists, chemists and biologists we cannot leave the conduct of medical research exclusively to them; we must in addition have persons who have gone through the broad training that the M.D. degree connotes, and only the medical schools can produce such persons. Without them medical research will not attain to the full stature of which it is capable.

To achieve this full stature the medical schools need unrestricted funds. If such money must come earmarked for research let it be on the broadest possible terms and not in the form of grants for restricted projects except as a last resort. It has been suggested that some of the national voluntary organizations that urge us to give our dollars to "fight" this or that disease might be well advised to donate at least a small fraction of the money they have collected to the medical schools for the general purposes of those institutions with a view to assisting them in the education of physicians some of whom, (who knows?) may later on discover the very weapon needed to destroy the particular disease which

these organizations have elected to wipe out. They can now make this contribution through the National Fund for Medical Education without fear of the charge that they may be playing favorites among the medical schools. If these agencies still insist upon giving the money they have collected from the public for research in the field represented by their particular pet disease then let them give lump sums to the schools as fluid research funds for the study of this or that disease, to be administered by the faculties of the schools as they think best, rather than attempt to follow advice from persons outside the schools as to how the money for such particular research should be spent.

To sum up briefly at this point, research in the medical schools is not in jeopardy for lack of money itself, but it will be in jeopardy through lack of trained research personnel if the medical schools cannot continue to give good training. The money now being made available to the schools for research should be made available on a less restricted basis than is currently the fashion. Great discoveries are quite as often the result of chance observations as they are of deliberately organized efforts to solve a particular problem.

I come now to the second danger which faces medical education, namely, the shrinkage of clinical material. This is a comparatively new threat but in many ways it seems to me a more sinister one than that of a lack of sufficient funds. It arises, paradoxically, from the fact that voluntary prepayment insurance plans to provide for the payment of hospital and doctors' fees are gaining such headway in this country.

Medical education cannot be satisfactory unless it is carried out in relation to the patient. By and large the reservoir of such patient-material, as all of you know, has consisted of the ward and the dispensary patient, that is the sick individual who did not have the money to pay for the cost of his care and was obliged therefore to seek the aid of those hospitals and clinics

which supply medical care gratis or at much less than cost.

But now the system is changing. Because of better economic circumstances in the country, because more people are taking out insurance which will enable them to meet their hospital bills and doctors' bills when they fall sick, because many are receiving medical care through the Veterans Administration, there are fewer persons who have to seek care on the public wards or in the out-patient departments of our hospitals than was formerly the case. Nowadays, thanks to Blue Cross and Blue Shield insurance, many persons can obtain accommodation on semi-private and private wards of a hospital and can command the services of a physician of their own choosing.

This situation, excellent as it is from the standpoint of the patient and the physician in private practice, is highly detrimental to the medical student and the young doctor who is seeking further training by serving one or more years as a member of the resident staff of one of our hospitals, whether teaching or non-teaching. Already more than one teaching hospital has felt the impact of this altogether new force which has made itself felt in the area in which we are all interested.

What can be done about it? We will all agree, I am sure, that the proper training of doctors must go on, not only at the medical student level, that is, pre-doctoral level, but also at the level of the hospital resident as well. We must bring our young men and women to the highest peak of medical knowledge and skill that is possible during the years that they are under our supervision, but this cannot be done without sufficient patients for them to care for under the proper supervision of their elders. Yet prepayment insurance plans work directly against this objective.

I have no pat answer to this problem, but I am reasonably certain of one thing and that is that it can be solved if those of you who are

in the active practice of medicine will understand the needs of the medical schools and the teaching hospitals in this respect and will cooperate by making some of your patients available for teaching purposes.

I venture to ask you members of the Faculty this question: Do you think that it would be practical for a teaching hospital to set aside a given number of its beds for undergraduate teaching and resident training purposes and say to the members of its staff—"every patient who is admitted to this restricted area, whether he be your patient or nobody's patient, shall be available for the instruction of undergraduates in the medical school and for the training of the resident staff up to the point of operation, if necessary, by a member of that staff, and, if you are not willing to accept this situation, we are sorry but we do not feel, in justice to what we conceive to be our mission, that we can any longer retain you as a member of our staff?" What will be your answer to that question?

Let me bring this problem a little closer to home. At least one of the services at the Baltimore City Hospitals now lacks sufficient patients to afford a satisfactory training for the house staff. As you know, that institution admits only indigent patients and those who can pay for the cost of their care are not admitted save as emergency cases. Let us suppose that the City authorities, desiring to increase the number of patients in order to make the services at the City Hospitals better training opportunities for the resident staff, should decide, as a matter of policy, to admit to that institution patients who can pay for their care either in whole or in part and charge them accordingly. What would the attitude of the Baltimore City Medical Society be toward such a proposal?

Some sort of an arrangement such as I have suggested must be put into effect if we are to retain the residency training system in full vigor.

That system, as far as America was concerned, was born right here in Baltimore and its father was the man for whom this very hall is named. That system is in real jeopardy at the moment, in my opinion, and, paradoxically, not as a result of some evil tendency or purposely malign action from without, but by a development which is altogether in the interest of the patient and the practitioner as well.

This problem is acute and serious here and now, and needs the greatest amount of careful thought by those who are responsible for keeping medical education at the highest level. Above all, however, it needs the sympathetic understanding of those who are in the front line of the practice of medicine.

Members of the Medical and Chirurgical Faculty of the State of Maryland, I have asserted in this address that the profession of medicine is not limited solely to those who are in the active practice of medicine. I have made so bold as to say that medical teaching and medical research are part and parcel of the profession of medicine, as well as medical practice. I base that contention on the inescapable fact that all three of these activities are directed toward one and the same end, namely the welfare of the sick human being. Because of that fact I have ventured to lay before you practitioners some of the problems which confront the medical schools of our country today. I have done so because those schools need your sympathetic understanding and your active assistance in their attempts to solve their difficulties, particularly as they relate to the supply of clinical material for teaching purposes. I for one am confident that once you fully understand the problems in this area you will not hesitate to come forward with the advice and the assistance which only you as active practitioners of medicine are in a position to give. That you will do so in fullest measure I have no doubt whatsoever.

Business Sessions

HOUSE OF DELEGATES

*Small Hall, 1211 Cathedral Street
Baltimore*

SPECIAL SESSION

Monday, April 28, 1952, 2:00 p.m.

The 198th meeting of the House of Delegates was called to order at 2:00 p.m., with Dr. Alan M. Chesney, President, presiding. Dr. Chesney called upon Dr. Walter D. Wise to open the meeting with a word of welcome to the Delegates, who in turn presented Dr. Chesney with the Gavel.

Dr. Chesney announced that the roll call of this assembly would be by registration. The following members registered: Doctors Thurston R. Adams, Warde B. Allan, J. T. B. Ambler, David H. Andrew, E. Cowles Andrus, Charles R. Austrian, O. H. Binkley, J. W. Bird, Helen Bowie, Read N. Calvert, Robert V. Campbell, Ferdinand E. Chatard, J. Albert Chatard, Alan M. Chesney, Osborne D. Christensen, Thomas A. Christensen, Richard G. Coblentz, George C. Coulbourn, Melvin B. Davis, H. A. Cantwell, Wilson Grubb, Everett S. Diggs, Norman S. Dudley, C. Reid Edwards, Monte Edwards, Wolcott L. Etienne, Houston S. Everett, Whitmer B. Firor, Warfield M. Firor, William E. Gilmore, John Evans, Lewis P. Gundry, A. McGehee Harvey, Robert F. Healy, Donald Hooker, James G. Howell, Hugh J. Jewett, James R. Karns, Joseph W. Ketsky, Harry F. Klinefelter, J. H. Mason Knox, III, Louis Krause, F. Ford Loker, William B. Long, W. Kenneth Mansfield, James T. Marsh, W. O. McLane, Hugh B. McNally, Claude W. Mitchell, Zachariah R. Morgan, Waldo B. Moyers, William D. Noble, John W. Parsons, Nathan E. Needle, Edmund R. Novak, Maurice C. Pincoffs, M. C. Porterfield, H. William Primakoff, Peter P. Rodman, John K. Rozum, John E. Savage, Benedict Skitarelic, Francis J. Townsend, Jr., Ralph P. Truitt, Lawrence R. Wharton, P. F. C. Williams, Walter D. Wise, Eldridge H. Wolff, Joseph G. Bird, John Newell Classen, Bernard J. Cohen, Newland E. Day, Palmer H. Fletcher, Ross Z. Pierpont, Richard T. Shackelford, W. H. Townshend, General Robert P. Williams, and George H. Yeager.

The minutes of the meeting of September 14, 1951 were approved on motion of Dr. Charles R. Austrian.

At the request of Dr. Chesney, Dr. Hugh J. Jewett discussed the problem of proposed changes in the Blue Shield Insurance Plan. The enrollment of Blue Shield has been far below the hopes and expectations of that organization. It was felt there were three reasons why a better enrollment had not been secured:

1. The cost of a family subscription was approximately five times that of an individual subscription.

2. The fee schedule was unsatisfactory for those subscribers who were over the complete coverage according to income status, and likewise the fee schedule was unsatisfactory to a good many doctors.

3. The Income limits which had been set are too low for the present cost of living index.

In elaborating upon the difficulties in overcoming the obstacles of the present income limit, Dr. Jewett stated that in order that any plan be effective, 75% of all subscribers must have full coverage. Our present plan covers only approximately 55%; by increasing the income levels to \$4,500 for a family plan and to \$3,600 for a married couple, a little better than 71.3% of the present subscribers would have full coverage.

Dr. Ferguson moved that the proposed changes of the Blue Shield plan be approved. This was seconded and opened for discussion. In this discussion several objections were developed.

Dr. McNally and Dr. Mansfield stated that the decrease in the payment for obstetrical care was unsatisfactory and would result in most obstetricians withdrawing from the plan as participating physicians. An expression was likewise made that the internists felt that the decrease in the daily fee from \$4.25 to \$4.00 was ill-advised and that Baltimore County at least felt that this should be raised to \$5.00 per day. Several delegates suggested that an indemnity type of plan would be a more satisfactory solution to the difficulties which have arisen and which can be expected to arise in the future.

Mr. Dabney, the representative from Blue Cross and Blue Shield, discussed the difficulties of arriving at changes satisfactory to all concerned.

Dr. Pincoffs stated that it would be inadvisable to proceed with the proposed changes unless a large proportion of the physicians had expressed their views. It was likewise pointed out that though the Board of Directors of Blue Shield had the authority to make the necessary changes, the Board deemed it desirable to make only such changes as would satisfy the majority of participating physicians, as well as present or potential subscribers.

At the request of Dr. E. H. Wolff, a roll call by counties was made to determine whether or not the proposed changes in Blue Shield had been presented to the membership of each component society. It was found that 9 component societies had considered the proposed changes, 9 had not, and 5 counties were not represented at this meeting.

It was moved by Dr. Wolff that the proposed changes be

tabled. After verification of the fact that tabling of these proposals would not necessarily close the matter to future action, a vote was taken with the results that the motion to table these proposed changes was passed by a vote of 33 to 21.

Dr. Chesney called for the reports of the Officers and Committees. He stated that of the 38 reports to be given, only 10 carried recommendations. All of the reports have been abstracted and circularized to the membership. Dr. J. T. Marsh moved that the 28 reports, which have no recommendations, be approved as circularized. This was seconded and carried.

Secretary's Report. The report of the Secretary, Dr. Yeager, was given and the following recommendations concerning the appointment of a Committee to confer with the Building Fund Committee in reference to suggested changes in the physical setup of the office of the Faculty were carried on motion made by Dr. Binkley:

1. *That a Committee of the Medical and Chirurgical Faculty consult with representatives of the Building Fund Committee, of which Dr. Albert E. Goldstein is Chairman, with reference to suggested changes, in order to determine whether said changes could not be made to conform with plans for the eventual enlargement and alteration of 1211 Cathedral Street.*

2. *That this Committee consider a method of financing these changes, if present Faculty funds are inadequate.*

3. *In making a survey of recommended changes, it is suggested that the Small Hall could be converted into an adequate series of offices (by temporary partitions). In addition one area of Osler Hall could be screened by temporary partitions for small sectional meetings that are now held in the Small Hall.*

4. *The present front offices would be used as an information center, switchboard center, and such other facilities as deemed advisable by Mr. Kirkman, the Director.*

Council. Dr. C. Reid Edwards then read the following recommendations, which he proposed as Chairman of the Council:

1. *At this time I would like to extend the appreciation of the Medical and Chirurgical Faculty to Dr. A. C. Gillis, whose tenure of office on the Library Committee expired on December 31st, 1951, for his untiring efforts over these many years on behalf of the Library while he so ably served as Chairman of the Committee. I would like to recommend that this body take official action and that Dr. Gillis be so notified in a letter of appreciation, and that the same be incorporated into these minutes.*

2. *Due to the expenses encountered by the host component medical society at the Semiannual Meeting, it was the consensus of opinion that the Faculty should bear some of the expense. At this time \$700 is allowed in the budget for the Annual Meeting, so Council suggested that \$400 be used for the usual expenses and \$300 be supplied by the Faculty to the host component society to help defray the cost; however, it is understood that additional expenses incurred should be borne by the local society.*

3. *The following members are recommended for emeritus membership:*

Dr. Frances E. Weitzman, Annapolis
Dr. DeWitt B. Casler, Baltimore City
Dr. Karl W. Ebeling, Baltimore City
Dr. Edgar B. Friedenwald, Baltimore City
Dr. Howell I. Hammer, Baltimore City
Dr. Roy W. Locher, Baltimore City
Dr. Harry D. McCarty, Baltimore City
Dr. Fuller Nance, Baltimore City
Dr. Edwards A. Park, Baltimore City
Dr. Howard Tonolla, Baltimore City
Dr. A. McC. Stevens, Easton

Dr. W. L. Etienne questioned the policy in Dr. Edwards's report that matters of professional conduct be referred to the Professional Conduct Committee of the State Society rather than being handled on a local level. It was his feeling that whenever possible the component society should handle its local grievances. Dr. Edwards concurred in this policy.

Dr. Pierpont requested clarification of Dr. Edwards's report of the action of the Board of Medical Examiners in revoking the licenses of physicians who have been convicted of income tax evasion. In the absence of any member of the Board of Medical Examiners, Dr. Pincoffs stated that the Council has taken the action of supporting the policy of revoking licenses for income tax evasion, but that it has taken no public stand concerning reinstatement. He further stated that the State Board of Medical Examiners functions as an autonomous body without responsibility to or under the influence of the State Medical Society except for the fact that, as quoted from the Constitution and By-Laws, "The members of the Board of Medical Examiners of Maryland shall be nominated at the first meeting of the House of Delegates and presented to the entire Faculty at the regular Annual Meeting. Additional nominations for the Board of Medical Examiners may be made from the floor at the General Meeting just preceding the election. Such members nominated for the State Board of Medical Examiners shall be voted upon at one o'clock of the second day of the Annual Meeting."

Dr. E. H. Wolff then requested information concerning the policy of revoking the license of a physician who has been committed to a mental institution. Dr. Yeager stated that the exact policy was not known, but it was his feeling that the Medical Board of Examiners would not take action unless formal notice and request for investigation was given to the Board concerning a physician being committed to a mental institution.

It was moved by Dr. Marsh, seconded and carried that the report of the Council be accepted.

Committee on Scientific Work and Arrangements. Dr. Beverley C. Compton, Chairman of the Committee on Scientific Work and Arrangements read the following recommendations, which on motion of Dr. Pierpont were duly seconded and approved:

BE IT RESOLVED, that the Committee on Scientific Work and Arrangements recommends to the House of Delegates of the Medical and Chirurgical Faculty that the com-

mittees of the Faculty, the Baltimore City Medical Society, its Sections, the hospitals in the City of Baltimore, the nursing organizations be requested not to hold meetings in April which will detract from the attendance at the Annual Meeting of the Medical and Chirurgical Faculty.

BE IT FURTHER RESOLVED, that it is the hope of the Committee on Scientific Work and Arrangements that if the above mentioned organizations, societies, etc. find it impossible to omit meetings in the month of April that said meetings be held at least three weeks preceding the Annual Meeting of the Medical and Chirurgical Faculty.

Dr. Compton asked if a decision might be reached concerning the location of the Semiannual Meeting in 1952. It was moved that the Semiannual Meeting in 1952 be held at Ocean City, Maryland, and carried by vote.

Committee on Maternal and Child Welfare. In the absence of Dr. Louis H. Douglass, Chairman of the Committee on Maternal and Child Welfare, the following recommendations of this Committee were read by the Secretary:

1. *The comparatively high maternal mortality rate among negroes is an indication of the dire need for better care and more hospital beds for these individuals. It is felt that better care will be an automatic result of hospital beds. In those communities where beds were made available, there has been a decided decrease in mortality. Your Committee urges that the Faculty do all in its power in this direction.*

2. *The fact that more than 40% of the deaths were due to hemorrhage points a dramatic finger to the great need for more blood banks in strategic locations, to serve a fairly large area. Again the assistance of the Faculty is sought in the solving of this problem. These blood banks would be of value not only to obstetricians, but to all members of the profession.*

It was moved by Dr. Savage that these recommendations be accepted, seconded and carried.

Tuberculosis Committee. The following recommendations of the Tuberculosis Committee were likewise approved:

At present, the State requires admission of patients directly to the sanatorium, before they are sent to one of the General Hospitals in Baltimore for surgery. It is the feeling of this Committee, that it would be well if the State could find it possible to arrange for appropriate consultation in cases which require surgery and to admit them directly to the General Hospitals for this purpose, so that the patient may return home for continued care until a bed is available in the sanatorium. This would obviate the necessity of making patients, who are amenable to surgical treatment, wait weeks and months before anything can be done and during which time, the condition may become worse so that they will no longer be candidates for such therapy. It is true, that whenever possible, the State does admit these patients to their hospitals (sanatoria) before their turn. While this may be commendable, it is felt that patients who need medical treatment are prevented from entering in chronological order.

At this point, we emphasize the continued efforts to admit patients to the sanatoria in accordance with the medical indication. In those instances where patients are required to wait

at home for admission, it would be advisable to start medical treatment as soon as possible, and to this end, the City of Baltimore, through Dr. Silverman, has been supplying drugs such as Streptomycin and Para-aminosalicylic Acid. A similar arrangement for the patient in the State would be a definite improvement in the handling of their disease.

The Committee endorses the B.C.G. Vaccination Program which is being carried out in the City of Baltimore, and recommends that this type of work be extended throughout the State.

Committee on Rural Medicine. The recommendation of, the Committee on Rural Medicine was presented as follows, and Dr. Thomas A. Christensen moved that the recommendation be approved and that the Committee seek legal counsel, which was duly seconded and carried:

The Chairman spoke before the Junior Class at the University of Maryland on rural practice, and at that meeting attempted to determine whether the Juniors wish to spend their vacation in a rural hospital or possibly with a carefully selected rural doctor as a preceptor.

To date, we have had a very enthusiastic response regarding the intent of these young men to come into rural practice, and four men have volunteered for preceptorship this coming vacation period. We would like to have the Faculty advise whether or not they are in favor of this program and what legal status this relationship would involve.

Committee on Constitution and By-Laws. The report of the Committee on Constitution and By-Laws was deferred until a later meeting.

Committee to Consider the Relationship Between Hospitals and Specialties and the Manner of Payment for Professional Services. The following recommendations from this Committee were read to the House of Delegates:

1. *The Medical and Chirurgical Faculty recommends to hospitals that all specialists engaged in the fields of Radiology or Roentgenology, Pathology and Clinical Laboratory work, Anesthesiology and Physical Therapy (Physicians) be given Staff appointments in the same manner as given to all other physicians, in any given institution. The Faculty further recommends that financial or contractual arrangements made between the hospitals and the above specialists are to be recorded in writing, in duplicate, and a copy of these financial and contractual arrangements be given to the specialists.*

2. *That the Medical and Chirurgical Faculty recommend that all professional services rendered be billed for in the name of the physician rendering the service to the patient or responsible for such a service. In the event that there should be more than one member of the Staff of any Specialty, the bill should be rendered in the name of the responsible physician in that Department of Staff, e.g.: Consultation by Dr. Terwilliger and Staff, Production and Interpretation of X-Rays.*

3. *It does not appear to fall within the province of the Committee and Faculty to recommend to either individuals or Institutions, the matter of finances specifically. It does not appear unreasonable to recommend that the manner of pay-*

ment be a matter of local arrangements between the individual physician and an Institution, preferably to be related primarily to the volume of work and teaching required.

Dr. Skitarelic moved that these recommendations be approved. It was seconded by Dr. Parsons and carried.

Committee for the Study of Certain Phases of Medical Economics. Dr. Moyers reported for this Committee. He outlined the work which his Committee had done in arriving at the recommendations which they were presenting. As a result of circularization of a petition, it is the feeling of his Committee that the majority of physicians are in favor of the development of some type of legislation, which would cover his Committee's recommendations. It was his feeling that this should be at the State level and should at the present be limited to making some change in the present State Income Tax Laws. In making his recommendations, as follows, Dr. Moyers further stated that this Committee feels it has gone as far as it can and from now on this should be the problem of the Society:

1. *That the Medical and Chirurgical Faculty of Maryland make this problem one of its primary aims for the year and take the necessary action to prepare and present a bill to the Maryland Legislature incorporating the above ideas.*

2. *That the measures being taken by this Society in regard to this problem be presented to the House of Delegates of the American Medical Association in June 1952, without any recommendation for action by that body.*

3. *That an invitation be extended to other State Medical Societies to join in this movement.*

Dr. Savage moved that the House of Delegates go on record as being in favor of these recommendations and that Dr. Moyers's Committee be discharged with thanks. This was duly seconded and carried.

Rescinding Former Action on Tuberculosis Committee Recommendation. Dr. J. W. Bird requested that the action taken concerning the recommendations of the Tuberculosis Committee be reconsidered and he moved that the House of Delegates rescind a former action and refer these recommendations to the Advisory Committee of the Medical and Chirurgical Faculty, which has been formed to act in cooperation with the State Board of Health. After considerable discussion by Dr. Bird, Dr. Pierpont and Dr. Hetherington, the motion was carried.

The meeting adjourned at 4:05 p.m.

Respectfully submitted,

GEORGE H. YEAGER, M.D., *Secretary*

EVERETT S. DIGGS, M.D., *Assistant Secretary*

FIRST SESSION

Tuesday, April 29, 1952, 2 p.m.

The 199th meeting of the House of Delegates on April 29, 1952, was called to order by the President, Dr. Alan M. Chesney at 2:00 p.m., in the Small Hall, 1211 Cathedral Street, Baltimore.

The roll call was by registration and the following members were present: Doctors Thurston R. Adams, Warde B. Allan, J. T. B. Ambler, David H. Andrew, Charles R. Austrian, Helen Bowie, Read N. Calvert, Robert V. Campbell, H. A. Cantwell, Ferdinand E. Chatard, J. Albert Chatard, T. A. Christensen, Richard G. Coblenz, Bernard J. Cohen, George C. Coulbourn, Melvin B. Davis, Newland E. Day, Richard C. Dodson, George O. Eaton, John Evans, Wolcott L. Etienne, Houston S. Everett, Robert W. Farr, John S. Fenby, John M. T. Finney, Jr., Whitmer B. Firor, Warfield M. Firor, Palmer F. Futcher, William E. Gilmore, A. McGehee Harvey, Robert F. Healy, James G. Howell, Hugh J. Jewett, James R. Karns, William B. Long, W. Kenneth Mansfield, James T. Marsh, James N. McCosh, Hugh B. McNally, Claude B. Mitchell, Zachariah R. Morgan, Waldo B. Moyers, John W. Parsons, Harold B. Plummer, M. C. Porterfield, John O. Robben, John K. Rozum, John E. Savage, Richard T. Shackelford, Francis J. Townsend, Jr., W. H. Townshend, Jr., Ralph P. Truitt, Lawrence R. Wharton, Eldridge H. Wolff, Everett S. Diggs and George H. Yeager.

The reading of the minutes of the meeting held on Monday, April 28, 1952, were dispensed with on motion.

Dr. John M. T. Finney spoke to the House of Delegates concerning the proposed changes in the Maryland Medical Service Plan. He expressed the feeling of the Council that the tabling of the motion yesterday, necessitated a reconsideration of the proposals from Blue Shield. If Blue Shield is to compete on a favorable basis with commercial insurance companies, and if Blue Shield is to remain actuarially sound, changes such as they have proposed, modified by the desires of the Component Societies are necessary. Prompt action is essential. In order for definitive action to be taken there is a choice of calling a special session of the House of Delegates to reconsider these proposals after instruction of the delegates by their Component Societies, or a second choice of permitting Council to act for the Society as a whole after an expression of opinion has been obtained from the Component Societies and specialty groups. Dr. Finney then presented a statement from Council, that the Council requests authority to speak for the Society as a whole before the next Semi-annual Meeting, in the event that a majority of the Component Societies and the specialty groups involved have agreed to the proposals from the Maryland Medical Service, Inc. He then made a motion that this authority be granted. This was seconded and motion discussed from the floor. Most of the discussion was based on the method of obtaining the wishes of the Component Societies and the specialty groups. Clarification of the word, "majority," was likewise discussed and it was pointed out to the House of Delegates that no action will be taken by the Council or any other group until all possible information available from Component Societies and specialty groups and Blue Shield has been correlated. In accordance with the motion, unless there is a majority of opinion in favor of the proposals, the Council does not have the authority to act.

Dr. Yeager expressed his hope that the experience of the present meeting and that of yesterday will impress upon the delegates the importance of their position in the State Society

and the necessity of their being instructed by their Component Societies as to how to act in all matters of policy.

Dr. Etienne moved that the motion be amended to read that "the members of the House of Delegates be polled between May 20th and May 25th, and that the Council be guided by the results of their poll. This was seconded and the amendment opened for discussion. During the discussion Dr. Mitchell questioned the parliamentary procedure of discussing the subject that had been tabled. It was pointed out by Dr. Austrian that the motion had been tabled and the subject could be reopened for discussion at any time. The purpose of the motion was simply to the effect that the Council be given authority to act as a ballot counter and thereby to act in accordance with the desires of the majority of the Component Societies. The amendment to the motion was voted upon and was carried 23 to 12. The motion as amended was then voted upon and carried unanimously.

Dr. Lawrence R. Wharton, Chairman of the Committee on Constitution and By-Laws then read the proposed amendment to the Constitution as follows:

Article VIII. Sessions and Meetings. (Amendment in capital letters)

Section 1. The Annual Meeting of the Faculty shall be held in the City of Baltimore IN THE SPRING, THE TIME TO BE DESIGNATED EACH YEAR BY THE PRESIDENT OF THE FACULTY AND THE COUNCIL AT, OR PRECEDING, THE JUNE MEETING OF THE COUNCIL, and the Semiannual meetings may be called at such time and place as the Council may designate.

It was moved and seconded that this change be ratified. The motion was carried unanimously.

Dr. Wharton then read the proposed amendments to the By-Laws, listed below, on which final action will be taken at the meeting of April 30, 1952. No action could be taken at this time.

Chapter I. Membership. (Amendment in capital letters)

Section 3. Associate Members. Doctors of Medicine or those holding academic degrees of equal rank, who are not engaged in the private practice of medicine, shall be eligible for associate membership.

ONLY THOSE ASSOCIATE MEMBERS WHO PAY THE FULL RATE OF \$15.00 PER YEAR SHALL RECEIVE THE JOURNAL, WITHOUT ADDITIONAL COST. (This is a new paragraph, and has never appeared in the Constitution before. The remainder of Section 3 is unchanged.)

Chapter II. Dues.

Section 2. The annual dues for associate members shall be \$15.00 per year, and shall be payable January 31, in advance with the following exception: . . . (Remainder of section unchanged. The amendment is to change the

dues of Associate members from \$5 00 to \$15.00.)

The meeting was then adjourned for a five minute recess.

SECOND SESSION

Tuesday, April 29, 1952, 3:05 p.m.

The 200th meeting of the House of Delegates, held on Tuesday, April 29, 1952, was reconvened at 3:05 p.m. At the request of the President, Dr. Chesney, nominations were presented as follows, by Dr. J. Mason Hundley, Jr., Chairman of the Nominating Committee:

NOMINATIONS FOR 1953

<i>President</i>	Maurice C. Pincoffs, Baltimore
	{ George O. Eaton, Baltimore
	{ Osborne D. Christensen, Salisbury
<i>Vice-Presidents</i>	{ William F. Williams, Cumberland
	{ (Also to fill unexpired term of Dr.
	{ W. A. Gracie, 1952 deceased)
<i>Secretary</i>	George H. Yeager, Baltimore
<i>Treasurer</i>	J. Albert Chatard, Baltimore
	{ Charles R. Austrian, Baltimore (1955)
	{ Hugh J. Jewett, Baltimore (1955)
<i>Councilors</i>	{ William B. Long, Salisbury (1955)
	{ Walter D. Wise, Baltimore (1955)
Delegate to American Medical Association	Warde B. Allan, Baltimore (1953, 1954)
Alternate Delegate to American Medical Association	Louis H. Douglass, Baltimore (1953, 1954)
Committee on Scientific Work and Arrangements	{ Beverley C. Compton, Baltimore, <i>Chairman</i>
	{ William L. Garlick, Baltimore
	{ Edwin H. Stewart, Jr., Baltimore
Library Committee	William K. Diehl, Baltimore (1957)
Finney Fund Committee	I. Ridgeway Trimble, Baltimore (1957)
Board of Medical Examiners	{ Edward M. Hanrahan, Jr., Baltimore (1956)
	{ John E. Legge, Baltimore (1956)

Nominating Committee

J. Mason Hundley, Jr., *Chairman*, Baltimore
 J. Tyler Baker, Easton
 E. I. Baumgartner, Oakland
 Simon Brager, Baltimore
 Edward F. Cotter, Baltimore

The President then requested nominations from the floor but none were made.

Dr. Melvin B. Davis, Baltimore County, requested the floor and stated to the House of Delegates that the Presidency and the membership of the Council seems to have been dominated by Baltimore City. Dr. John Finney after

checking the record pointed out that in the last twelve years there have been five Presidents elected from outside of Baltimore City. It was felt by Dr. Finney that a closer check of the record would show that the ruling which has persisted for many years, of a President being elected from Baltimore City two years, and a representative from the County being elected the third year had been maintained and that in all probability County representation had been more frequent than had been suggested heretofore.

The meeting adjourned at 3:20 p.m.

Respectfully submitted,

GEORGE H. YEAGER, M.D., *Secretary*

EVERETT S. DIGGS, M.D., *Assistant Secretary*

THIRD SESSION

Wednesday, April 30, 1952, 9:30 a.m.

The 201st meeting of the House of Delegates was called to order by the President, Dr. Alan M. Chesney, at 9:30 a.m. at 1211 Cathedral Street.

The roll call was by registration and the following members were present: Doctors Thurston Adams, J. T. B. Ambler, E. Cowles Andrus, Jacob W. Bird, Read N. Calvert, T. Nelson Carey, Ferdinand E. Chatard, J. Albert Chatard, Bernard J. Cohen, George C. Coulbourn, Newland E. Day, George O. Eaton, Monte Edwards, Wolcott L. Etienne, John Evans, Houston S. Everett, Robert W. Farr, John S. Fenby, John M. T. Finney, Whitmer B. Firor, Palmer H. Fitcher, A. McGehee Harvey, Robert F. Healy, James G. Howell, James R. Karns, J. H. Mason Knox III, Louis Krause, William T. Layman, Franklin E. Leslie, F. Ford Loker, W. Kenneth Mansfield, James T. Marsh, Hugh B. McNally, Claude W. Mitchell, Zachariah R. Morgan, Waldo B. Moyers, John W. Parsons, Ross Z. Pierpont, M. C. Porterfield, H. William Primakoff, John E. Savage, Richard T. Shackelford, Francis J. Townsend, Jr., W. H. Townshend, Jr., Ralph P. Truitt, Lawrence R. Wharton, Palmer F. C. Williams, Walter D. Wise, Frank Wobert, Jr., Eldridge H. Wolff.

The reading of the minutes of the first and second sessions, held on Tuesday, April 29, 1952, were dispensed with on motion passed.

The nominations for officers and members of the Council were presented to the House of Delegates and on the motion made by Dr. W. McLane and duly seconded, the Secretary was directed to cast the unanimous ballot for election of the proposed slate as follows:

President.....Maurice C. Pincoffs, Baltimore

Vice-Presidents.....George O. Eaton, Baltimore

Osborne D. Christensen, Salisbury

William F. Williams, Cumberland

(Also to fill unexpired term of Dr. W.

A. Gracie, 1952 deceased)

Secretary.....George H. Yeager, Baltimore

Treasurer.....J. Albert Chatard, Baltimore

Councilors.....Charles R. Austrian, Balto. (1955)

Hugh J. Jewett, Balto. (1955)

William B. Long, Salisbury (1955)

Walter D. Wise, Balto. (1955)

Delegate to Ameri-

can Medical Asso-

ciation.....Warde B. Allan, Balto. (1953, 1954)

Committee on Scien-

tific Work and Ar-

rangements.....Beverley C. Compton, Balto., Chair-

man

William L. Garlick, Balto.

Edwin H. Stewart, Jr., Balto.

Library Committee...William K. Diehl, Balto. (1957)

Finney Fund Commit-

tee.....I. Ridgeway Trimble, Balto. (1957)

Dr. Chesney announced that the election of members to the Board of Medical Examiners would take place today, at 12:30 p.m., in Osler Hall.

The proposed Amendments to the By-Laws were then acted upon by the House of Delegates. It was moved by Dr. Woody, seconded and carried that: Chapter I, Section 3, read as follows:

Chapter I. Membership. (Amendments in capital letters)

Section 3. Associate Members. Doctors of Medicine or those holding academic degrees of equal rank, who are not engaged in the private practice of medicine, shall be eligible for associate membership.

ONLY THOSE ASSOCIATE MEMBERS WHO PAY THE FULL RATE OF \$15.00 PER YEAR SHALL RECEIVE THE JOURNAL, WITHOUT ADDITIONAL COST. (This is a new paragraph, and has never appeared in the Constitution before.)

(The remainder of Section 3 is unchanged.)

It was moved by Dr. Mitchell, seconded by Dr. Porterfield, and motion passed that Chapter II, Section 2 be amended as follows:

Chapter II. Dues.

Section 2. The annual dues for associate members shall be \$15.00 per year, and shall be payable January 31, in advance, with the following exception: . . . (Remainder of section unchanged.)

(The amendment is to change the dues of associate members from \$5.00 to \$15.00.)

It was moved by Dr. John Finney, seconded by Dr. Moyers and motion carried that Chapter VIII, Section 1, be amended to read as follows:

Chapter VIII. Standing Committees.

Section 1. (Paragraph II) The standing committees, WHICH ARE, to be named by the President, ARE: Nominating Committee, RESOLUTIONS COMMITTEE.

(Paragraph III) Standing Committees, organized as hereinafter provided, are: House Committee, Finance Committee, PROFESSIONAL CONDUCT COMMITTEE AND RESOLUTIONS COMMITTEE.

It was moved by Dr. Marsh, seconded by Dr. Morgan and motion carried that Chapter VIII, Section 8, be amended to read as follows:

Chapter VIII.

Section 8. PROFESSIONAL CONDUCT COMMITTEE. This Committee shall consist of the five immediate Past Presidents of the Medical and Chirurgical Faculty with the SENIOR PAST PRESIDENT as Chairman of the Committee. The function of this Committee will be to hear legitimate grievances against members of the Society, examine the facts of the grievances and make recommendations as to their disposition to the Council of the Faculty.

It was moved by Dr. Wise and seconded by Dr. Whitmer Firor, and motion carried that Section 9 of Chapter VIII, forming a Resolutions Committee be adopted as follows: Chapter VIII.

Section 9. RESOLUTIONS COMMITTEE. THE RESOLUTIONS COMMITTEE SHALL CONSIST OF FIVE MEMBERS TO BE APPOINTED ANNUALLY BY THE PRESIDENT OF THE MEDICAL AND CHIRURGICAL FACULTY, WHO SHALL ALSO DESIGNATE THE CHAIRMAN OF THE RESOLUTIONS COMMITTEE. THIS COMMITTEE SHALL BE CHOSEN FROM THE HOUSE OF DELEGATES, AND SHALL BE APPOINTED AT LEAST 30 DAYS BEFORE THE ANNUAL MEETING OF THE HOUSE OF DELEGATES.

ANY NEW BUSINESS INVOLVING A QUESTION OF POLICY, WHICH HAS NOT PREVIOUSLY BEEN CONSIDERED BY THE COUNCIL OR THE HOUSE OF DELEGATES, SHALL BE REFERRED TO THE RESOLUTIONS COMMITTEE FOR CONSIDERATION, BEFORE BEING ACTED ON BY THE HOUSE OF DELEGATES. THE RESOLUTIONS COMMITTEE SHALL REPORT TO THE HOUSE OF DELEGATES AT THE TIME INDICATED BY THE CHAIRMAN OF THE HOUSE OF DELEGATES.

The report of the Committee to Cooperate with the American Medical Education Foundation was read by the Secretary as follows:

1. *The Committee unanimously recommended that the Faculty allocate a sum of money, (the recommended amount \$2000.00), for individual member contribution campaign and expenses thereby connected with circularizing etc., American Medical Education Foundation.*

2. *That the name of all contributors be published in the Maryland State Medical Journal. The amount will not be included.*

Dr. Adams reported for the Committee that they had met the day before and it is their intent to canvass each member of the Society, solicit from him a personal contribution toward the Foundation and to put informative notices in the State Journal and the Alumni Journal of both Medical Schools as to the purpose of the Committee. In addition to this solicitation, the names of the contributors, but not the amounts any individual contributed would be printed in the Maryland State Medical Journal. The sum of \$2000.00 requested was thought to be the probable amount of money necessary to defray the cost of such a campaign. At the request of the President, Mr. Kirkman addressed the House of Delegates and stated that the same objective might be accomplished with less money and suggested that the amount of money allocated be left to the discretion of the Council.

Dr. Day, Chairman of the Committee, pointed out that there were many other costs besides those of circularization; that he was willing to accept any amount of funds they might allot him with the understanding that the activity of the Committee would have to be limited if the appropriation were smaller. He likewise pointed out that larger amounts have been contributed directly by State Societies to the Foundation.

Dr. Chatard felt that the Society could help out financially, but did not feel that we could afford the total amount requested.

Dr. Andrus suggested that a letter of solicitation be included in the same envelope with the American Medical Association dues. Dr. Fitcher suggested withholding of a certain percentage of the money collected in order to defray the expense, the administrative expense.

Dr. Day pointed out that one of the great selling points in the campaign was to the effect that none of the money contributed personally by the physicians was used for administrative purposes. Dr. Moyers expressed his opinion that more than a solicitation was required, that a definite campaign would be essential. Dr. Day reported that such a position had already been reached by his Committee, and was part of the program which the Committee had planned. This type of campaign, however, would involve travel expenses and unless such expenses could be charged directly to the Society, there must be a sufficient amount of money allocated to the Committee to cover their traveling expenses.

Dr. Pincoffs moved that the House of Delegates approve this resolution in principle and request the Council to take such steps in this direction as its finances will permit. This was seconded and carried.

Dr. Harry F. Klinefelter, Jr., then presented a resolution concerning the coordination of Government Medical Services: "Creation of a Federal Department of Health." He explained that this was presented as an endeavor to have the American Medical Association consider the principles proposed in Bill S-1140 more thoroughly and such changes as to make such a bill effective. The resolution was then read as follows:

WHEREAS, the important legislative bill (S-1140) for the creation of a Federal Department of Health, has been debated

before the Sub-Committee on Reorganization of the Senate Committee on Government Operations, where the proponents included five doctors of prominence, and

WHEREAS, this legislation is expected shortly to be considered by a House Committee in further hearings, and

WHEREAS, the American Medical Association, through witnesses appearing before the Senate Sub-Committee, expressed approval of the intent and purposes of this proposal, objecting only to some of its provisions, and

WHEREAS, it is widely admitted that the unification of 35 competing Federal medical services would result in greater efficiency and economy and make for conditions better for doctors and for the public, therefore be it

RESOLVED, that this body shall respectfully ask the American Medical Association to formulate amendments to the Bill which would meet the Association's objections, or suggest such compromises as will clear the way for the adoption of the admittedly needed reorganization of Federal medicine. And be it further

RESOLVED, that cooperation be given by all members of this Society by writing their Senators and Representatives in Congress calling for prompt legislation to improve the Federal medical services, and

That copies of this resolution be sent to Dr. John W. Cline, President of the American Medical Association, and to the National Doctors Committee for Improved Federal Medical Services, 15 West 46th Street, New York 36, New York.

On motion of Dr. Fitcher, duly seconded, this resolution was approved.

Dr. Krause then presented a resolution from the Geriatrics Committee of the Baltimore City Medical Society. By way of background he pointed out that many of the Homes for the Aged are located in Counties and that because of this and of the fact that the Baltimore City Society felt that the State as a whole should be aware of the geriatrics problem that this resolution, as follows, was being presented:

WHEREAS, the Committee on Geriatrics of the Baltimore City Medical Society, of which Dr. Herman Seidel is Chairman, unanimously requests that there be a similar committee on a state-wide basis,

BE IT RESOLVED, that the House of Delegates of the Medical and Chirurgical Faculty authorize the appointment of a Geriatrics Committee, and

BE IT FURTHER RESOLVED, that the President of the Medical and Chirurgical Faculty appoint said Geriatrics Committee.

It was moved by Dr. Finney and seconded by Dr. Woody that the resolution be approved.

Dr. Pincoffs pointed out the fact that the chief danger in building chronic hospitals lies in the fact that too often very fine structures are constructed but not much thought is given to the actual running of such institutions. He also stated that in the near future this will probably be considered by the State from a budget standpoint, as well as that of management, and that the State Society as a whole should be well acquainted with the problems and possible solutions of geriatrics. Such a committee could be well informed with the problems

and pass this information on to the Faculty for its consideration and action. The motion was carried.

Dr. George Eaton presented to the House of Delegates the resolution, submitted by the Baltimore City Medical Society in regard to formulating a plan to encourage more adequate distribution of general practitioners and specialists to areas in the State where they are needed, as follows:

WHEREAS, there are smaller communities and rural areas in the State of Maryland in which there is not a sufficient number of physicians to provide the local citizens with adequate medical care; and

WHEREAS, this lack of medical care in these areas is due primarily to a poor distribution of physicians rather than a deficient number of physicians per capita of population in the State; and

WHEREAS, this is a problem of direct concern to, and a moral responsibility of, the Medical Society of the State; therefore

BE IT RESOLVED by the Baltimore City Medical Society, that a recommendation be made to the Medical and Chirurgical Faculty of the State of Maryland that it formulate a plan whereby incentives shall be provided of sufficient attraction to encourage an adequate distribution of general practitioners and specialists to areas in the State where they are needed.

BE IT FURTHER RESOLVED, that the Baltimore City members of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland be instructed to urge upon the House of Delegates the adoption of such a plan.

Dr. Whitmer Firor moved that the resolution be adopted. This was seconded and opened for discussion.

Dr. Shackelford pointed out the difficulties which some of the young men are having getting located in some of the Counties where they would like to practice is primarily because of their inability to obtain hospital privileges. He felt that such a committee could be quite effective in paving the way for acceptance of qualified men in rural areas.

Dr. Wolff felt that the committee could also act to hear the other side of the question, namely that of the community in which the man might desire to practice, and thereby help the community in its selection or rejection of possible practitioners.

Dr. Pierpont suggested that the same problem which exists in the Counties is also present in Baltimore City and might likewise be considered by such a committee.

The motion was carried.

Dr. Chesney thanked the Committee on Scientific Arrangements for the excellent program and facilities which have been arranged for this meeting. He then introduced the President-elect of the Faculty, Dr. Maurice C. Pincoffs.

There being no further business, the meeting adjourned at 10:15 a.m.

Respectfully submitted,

GEORGE H. YEAGER, M.D., *Secretary*

EVERETT S. DIGGS, M.D., *Assistant Secretary*

GENERAL MEETING

Wednesday, April 30, 1952

12:30 p.m., Osler Hall

Election of State Board of Medical Examiners of Maryland

The election for two new members of the Board of Medical Examiners of Maryland was held at 12:30 p.m., Wednesday,

April 30, 1952. The meeting was called to order by the President, Dr. Alan M. Chesney. Two nominations were introduced from the House of Delegates, which nominated Drs. Edward M. Hanrahan, Jr., and John E. Legge to succeed themselves. Nominations were requested from the floor.

There being no additional nominations, it was moved, seconded, and unanimously carried, that the following be elected to the Board of Medical Examiners of Maryland: Edward M. Hanrahan, Jr., M.D. (1956) and John E. Legge, M.D. (1956).

REPORTS*

To the House of Delegates

SECRETARY'S REPORT

Mr. President and Members of the House of Delegates:

The total number of Faculty members is 2,451. There was a gain of 79 active members and 4 nonresident members, making an actual gain in membership of 83. (See Statistical Report.) The total number of Faculty members who have paid dues to the American Medical Association is 1,397.

As Secretary of the Medical and Chirurgical Faculty I again wish to emphasize the totally inadequate facilities for the office staff. There are now four full-time and two part-time secretaries, exclusive of Miss Wynde and Miss Edgar, crowded into three small, poorly ventilated offices.

The volume of work during my four and one-half years as Secretary of the Medical and Chirurgical Faculty has increased tremendously. The brunt of this has been borne by the office staff. Many extra hours of work in the evenings, holidays and Sundays, has been required. Various committees of the Faculty have become much more active; A. M. A. correspondence has become voluminous; the Woman's Auxiliary has become a well integrated activity, and the Journal has added immeasurably to the general office burden.

Eventually additional clerical assistance will be required. Meanwhile, it is imperative in order to improve the general working efficiency of the present staff that certain physical alterations be made. The following recommendations are presented for consideration:

1. *That a committee of the Medical and Chirurgical Faculty consult with representatives of the Building Fund Committee, of which Dr. Albert E. Goldstein is Chairman, with reference to suggested changes, in order to determine whether said changes could not be made to conform with plans for the eventual enlargement and alteration of 1211 Cathedral Street.*

* A summary of these reports, which were submitted by the Officers, Chairman of the Council, A. M. A. Delegates, and the Chairmen of the Committees, was mailed to every Delegate and the President and Secretary of each Component Society prior to the meeting of the House of Delegates on Monday, April 28, 1952.

2. *That this committee consider a method of financing these changes, if present Faculty funds are inadequate.*

3. *In making a survey of recommended changes, it is suggested that the Small Hall could be converted into an adequate series of offices (by temporary partitions). In addition, one area of Osler Hall could be screened by temporary partitions for small sectional meetings that are now held in the Small Hall or the "supper room" could be used without alterations for such meetings.*

4. *The present front offices could be used as an information center; switchboard center, and such other facilities as deemed advisable by Mr. Kirkman, the Director.*

Respectfully submitted,

GEORGE H. YEAGER, M.D., Secretary

TREASURER'S REPORT

Mr. President and Members of the House of Delegates:

Each Delegate has been given a copy of the financial statement.

In my recommendation to you last year, I noted how vitally necessary was the increase in dues. This increase has been more than justified as our expenses have increased over the last few years.

The budget as set up by Mr. Kirkman, our Director, is very comprehensive, and I can only say, without his help and advice during the last few years, we would still be floundering around.

My dream has at last come true and the "enlarged monthly Bulletin" is now a real first-class Medical Journal carrying news to all the members in the State and letting all see how much work is accomplished in the office for you and your medical life. I think this is the greatest step we have taken in cementing closer relations of our membership.

The past cannot be changed; but the future can be made more secure by our united efforts.

Respectfully submitted,

J. ALBERT CHATARD, M.D., Treasurer

Secretary's Report

April, 1952

MEMBER-SHIP 1951	MEMBER-SHIP 1952	PAID IN ADVANCE	COUNTIES	NEW MEMBERS	DECEASED	RESIGNED	REMOVED	DROPPED
79	77	68	Allegheny-Garrett County Medical Society	3	3	1	1	
49	52	48	Anne Arundel County Medical Society	7	1		2	1
153	154	136	Baltimore County Medical Society	12	3	1	6	1
1286	1339	1227	Baltimore City Medical Society—Active	90	17	4	12	4
74	89	81	Baltimore City Medical Society—Asso.	22			4	3
12	11	11*	Caroline County Medical Society				1	
5	6	6*	Calvert County Medical Society	1				
36	34	31	Carroll County Medical Society	1				3
20	18	18*	Cecil County Medical Society—Active	3			5	
13	11*	11*	Cecil County Medical Society—Asso.				2	
14	15	15*	Charles County Medical Society	1				
24	20	20*	Dorchester County Medical Society		1		3	
51	50	45	Frederick County Medical Society	3	3		1	
29	29	27	Harford County Medical Society—Active	2			2	
1	×		Harford County Medical Society—Asso.			1		
8	9	9*	Howard County Medical Society	1				
11	10	10*	Kent County Medical Society	1	2			
150	158	136	Montgomery County Medical Society—Act.	18	2		5	3
44	48	44	Montgomery County Medical Society—Asso.	9	1		1	3
68	72	56	Prince Georges County Medical Soc.—Act.	9			2	3
28	27	23	Prince Georges Co. Medical Soc.—Asso.	1			1	1
5	9	9*	Queen Anne's County Medical Society	4				
13	14	14*	St. Mary's County Medical Society	2	1			
12	10	10*	Somerset County Medical Society				2	
24	23	23*	Talbot County Medical Society				1	
71	70	69	Washington County Medical Society	2		2	1	
38	42	42*	Wicomico County Medical Society	6			2	
14	13	13*	Worcester County Medical Society—Act.			1		
	1	1*	Worcester County Medical Society—Asso.	1				
36	40	11	Non-resident Membership	4				
2368	2451	2214		203	34	10	54	22

ACTUAL GAIN—83

GAIN—Active Members— 79

GAIN—Non-Res. Members— 4

TREASURER'S FINANCIAL STATEMENT
For Period from January 1st, 1951 to December 31st, 1951
GENERAL FUND—INCOME AND EXPENSE STATEMENT

Income

Dues			
Baltimore City Dental Society.....	\$1,407.00		
Baltimore City Medical Society.....	33,744.50		
County Medical Societies.....	12,505.50		
Halls and Offices			
Baltimore City Medical Society.....	400.00		
Other.....	4,215.00	\$52,272.00	
<hr/>			
Meetings—Annual and Semi-Annual.....		1,535.36	
Woman's Auxiliary—For Salaries.....		100.00	
Baltimore City Medical Society			
For Salaries.....	\$2,475.00		
For Printing.....	250.00	\$2,725.00	
<hr/>			
Transfers from Consolidated Fund—Income Funds			
John Ruhrah Fund			
For Salaries.....	\$200.00		
For General Purposes.....	2,113.41	\$2,313.41	
<hr/>			
Charles M. Ellis Fund—For General Purposes.....	1,150.99	\$3,464.40	
<hr/>			
Total Income.....			\$60,096.76

Expense

American Medical Association Expense.....		\$58.22	
Accounting Fees—Portion.....		300.00	
Postage.....		1,468.22	
Telephone and Telegraph.....		1,673.02	
Contribution—National Society for Medical Research.....		50.00	
Floral Designs.....		10.20	
Fuel.....		2,526.37	
Gas, Electricity and Water.....		2,107.75	
Household and Janitorial Supplies.....		244.11	
Insurance.....		1,146.17	
Interest Paid.....		212.92	
Journal Expense.....		34.22	
Legal Fees.....		562.60	
Legislative Committee Expense.....		851.40	
Library Account			
Books and Journals.....	\$16.66		
Supplies and Expense.....	55.88	\$72.54	
<hr/>			
Maintenance of Property—Portion.....		1,301.04	
Maryland Unemployment Insurance.....		658.26	
Federal Unemployment Insurance.....		98.14	
Social Security Tax.....		957.31	
Medical Care Campaign Committee.....		49.00	
Meetings—Annual and Semi-Annual.....		3,513.10	
Miscellaneous Expense.....		2,106.19	
Purchase of Office Equipment.....		374.50	
Office Supplies.....		1,528.42	
Printing.....		3,189.49	
Salaries			
Janitors.....	\$7,550.50		
Clerical.....	27,025.65	\$34,576.15	
<hr/>			
Travel.....		431.88	
<hr/>			

Total Expense.....	\$60,101.22
December 31st, 1951—Excess of Expense Over Income	<u>\$4.46</u>

CONSOLIDATED FUND—INCOME FUNDS—INCOME AND EXPENSE STATEMENT
For Year Ended December 31st, 1951

Income

Income from Consolidated Fund Investments

Bonds

United States Government and Municipal.....	\$899.51	
Public Utility, Railroads, etc.....	<u>1,005.50</u>	\$1,905.01

Stocks

Common.....	\$8,508.80	
Preferred.....	<u>501.32</u>	\$9,010.12

Interest Special Savings Account—Maryland Trust Company.....	11.15	
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\$10,926.28

Less—Agencies Fees.....	<u>443.51</u>	
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Net Income from Investments.....	\$10,482.77
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Interest on Savings Accounts—Maryland Trust Company.....	<u>178.85</u>
--	---------------

Total Income.....	\$10,661.62
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Expenses

Special Purposes.....	\$641.25	
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Library Purposes.....	4,975.14	
-----------------------	----------	--

General Purposes—Portion of Maintenance of Property.....	309.26	
--	--------	--

Transfers to General Fund

Salaries.....	\$200.00	
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General Purposes.....	<u>3,264.40</u>	\$3,464.40
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Total Expense.....	\$9,390.05
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December 31st, 1951—Excess of Income over Expense	<u>\$1,271.57</u>
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CONSOLIDATED FUND—INCOME FUNDS BALANCE

January 1st, 1951 To December 31st, 1951

January 1st, 1951—Balance to Credit of Account.....	\$17,083.73
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Additions

Excess of Income over Expense—For Year Ended December 31st, 1951.....	\$1,271.57
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Transfer from General Fund for 1950 Advances.....	333.10
---	--------

Partial Payment from Baltimore City Medical Society.....	800.00
--	--------

Accounts Receivable—Baltimore City Medical Society.....	700.00
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Investment—Maryland Medical Service, Inc.....	<u>5,050.00</u>
---	-----------------

\$25,238.40

Deductions

Transfer to General Fund for 1950 Disbursements.....	\$58.70	
--	---------	--

Amount due General Fund for Balance of 1951 Disbursements.....	<u>5.73</u>	\$64.43
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December 31st, 1951—Balance to Credit of Account.....	<u>\$25,173.97</u>
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CONSOLIDATED FUND—INCOME FUNDS RECEIPTS, EXPENDITURES AND BALANCES

January 1st, 1951 to December 31st, 1951

FUND	RECEIPTS			EXPENDITURES					BALANCES—DECEMBER 31ST, 1951 REPRESENTED BY								
	BALANCES JANUARY 1st, 1951	Interest on Savings Accounts	Income from Investments Per cent	Amount	SUB-TOTAL	Special Purposes	Library Purposes	General Purposes	Transfers to General Fund	BALANCES DECEMBER 31st, 1951	Additions		Deductions		Balances December 31st, 1951		
											Savings Accounts	Unde- posited	Receiv- able	Invest- ment		Due Principal	Due General Fund
Baker.....	\$71.36	.70	.47	\$49.27	\$121.33		\$42.00			\$79.33	\$79.33				\$79.33		
Barker, Lewellys F.....	81.73	.70	.31	32.50	114.93		23.18			91.75	91.75				91.75		
Bowen, Josiah S.....	262.54	13.25	6.85	718.07	993.86			262.54		731.32	1,360.62			629.30	731.32		
Bressler, Frank C.....	46.72	.15	1.44	150.95	197.82			46.72		151.10	151.10				151.10		
Cordell, Eugene Fauntleroy.....	4,227.47	30.00	3.03	317.63	4,575.10	50.00				4,525.10	4,525.10				4,525.10		
Ellis, Charles M.....	None	None	10.98	1,150.99	1,150.99				1,150.99	None	None				None		
Finney, John M. T.....	1,354.29	18.10	6.79	711.78	2,084.17	126.25	606.55			1,351.37	1,351.37				1,351.37		
Frick, William F.....	3,023.12	30.00	11.74	1,230.66	4,283.78		1,047.71			3,236.07	3,231.57	4.50			3,236.07		
Friedenwald, Julius.....	96.25	.90	.59	61.85	159.00					159.00	159.00				159.00		
Harlan, Herbert.....	49.01	—	.66	69.19	118.20		57.65			60.55	60.55				60.55		
McCleary, Standish.....	57.82	.50	.62	65.00	123.32		50.70			72.62	72.62				72.62		
Osler Endowment.....	570.33	8.40	1.11	116.36	695.09					695.09	695.09				695.09		
Osler Testamental.....	530.13	8.25	6.78	710.74	1,249.12		295.74			953.38	953.38				953.38		
Ruhrak, John.....	10,564.26	30.00	41.31	4,330.44	14,924.70		2,552.46		2,313.41	10,058.83	4,314.56		5,050.00	5.73	10,058.83		
Stokes, William Royal.....	1,716.14	21.50	3.46	362.71	2,100.35		299.15			1,801.20	1,801.20				1,801.20		
Trimble, Isaac Ridgeway.....	1,122.93	14.55	2.10	220.14	1,357.62	465.00				892.62	892.62				892.62		
Woods, Hiram.....	128.30	1.85	1.76	184.49	314.64					314.64	314.64				314.64		
Totals.....	\$23,902.40	\$178.85	\$100.00	\$10,482.77	\$34,564.02	\$641.25	\$4,975.14	\$309.26	\$3,464.40	\$25,173.97	\$20,054.50	\$4.50	\$700.00	\$5,050.00	\$629.30	\$25,173.97	

CONSOLIDATED FUNDS—AMOUNTS IN PRINCIPAL FUND

December 31st, 1951

FUND	PURPOSE	AMOUNT
Baker.....	Books on Materia Medica.....	\$870.50
Barker, Lewellys F.....	Library.....	520.00
Bowen, Josiah S.....	General.....	11,807.29
Bressler, Frank C.....	General.....	2,400.00
Cordell, Eugene Fauntleroy.....	Relief of Widows and Orphans.....	4,847.97
Ellis, Charles M.....	General.....	6,000.00
Finney, John M. T.....	Books, Journals and Lectureships on Surgery.....	11,181.32
Frick, William F.....	Maintenance Frick Library, Purchase Books and Journals.....	20,000.00
Friedenwald, Julius.....	Maintenance of Friedenwald Room.....	1,000.00
Harlan, Herbert.....	Books on Ophthalmology.....	1,015.00
McCleary, Standish.....	Lectureships and Books on Pathology.....	1,000.00
Osler Endowment.....	Permanent Endowment for Books and Buildings, by request of Dr. Osler.....	1,860.98
Osler Testimonial.....	Medical Books and Maintenance of Osler Hall.....	10,316.99
Ruhrah, John.....	Library, Books and Journals, etc.....	54,317.86
Stokes, William Royal.....	Lectureships and Books on Bacteriology.....	4,119.59
Trimble, Isaac Ridgeway.....	Lectureships Only.....	3,519.25
Woods, Hiram.....	General.....	3,000.00
Total.....		<u>\$137,776.75</u>

FUNDS INVESTED IN FIXED ASSETS—PRINCIPAL

December 31st, 1951

January 1st, 1951—Balance to Credit of Account..... \$391,272.71

Additions

1950 Purchases previously charged to Expense

March 27th, 1950—One Green Two-drawer letter file.....	\$38.25	
April 21st, 1950—One Three-drawer card file.....	29.25	
December 20th, 1950—One Desk (Used).....	25.00	\$92.50

1951 Purchases

January 22nd, 1951—One Chair, Du-More.....	\$31.25	
May 28th, 1951—One Metal File, Four Drawer.....	83.50	
June 15th, 1951—One Chair, Du-More.....	36.00	
June 26th, 1951—One Metal Desk and Chair.....	223.75	\$374.50

December 31st, 1951—Balance to Credit of Account..... \$391,739.71

BUILDING FUND—PRINCIPAL

January 1st, 1951 to December 31st, 1951

January 1st, 1951—Balance to Credit of Account..... \$39,029.10

Additions

Payments on Pledges.....	\$14,675.79		
Interest			
Savings Accounts.....	\$137.00		
United States Government Bonds.....	700.00	\$837.00	\$15,512.79
			<u>\$54,541.89</u>

Deductions

Bond Premium.....	\$12.50	
Campaign Expenses.....	160.34	\$172.84
December 31st, 1951—Balance to Credit of Account.....		<u>\$54,369.05</u>

CONTINGENT FUND

January 1st, 1951 to December 31st, 1951

INCOME

January 1st, 1951—Balance to Credit of Account.....	\$600.62
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Additions

Dividends.....	\$231.00	
Interest		
Government Bonds.....	125.00	
Savings Account.....	9.15	\$365.15
		<u>\$965.77</u>

Deductions

Portion of Accounting Fees.....	\$389.17	
Agency Fee.....	30.70	\$419.87
December 31st, 1951—Balance to Credit of Account.....		<u>\$545.90</u>

PRINCIPAL

January 1st, 1951—Balance to Credit of Account.....	\$9,921.30
No changes during year.....	—
December 31st, 1951—Balance to Credit of Account.....	<u>\$9,921.30</u>

NELLIE N. COWLES BEQUEST FUND

January 1st, 1951 to December 31st, 1951

INCOME

January 1st, 1951—Balance to Credit of Account.....	None
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Addition

Interest—United States Government Bonds.....	\$25.00
December 31st, 1951—Balance to Credit of Account.....	<u>\$25.00</u>

PRINCIPAL

January 1st, 1951—Balance to Credit of Account.....	\$1,000.00
No changes during year.....	—
December 31st, 1951—Balance to Credit of Account.....	<u>\$1,000.00</u>

MEDICAL ANNALS FUND

January 1st, 1951 to December 31st, 1951

January 1st, 1951—Balance to Credit of Account.....	\$766.73
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Addition

Interest on Savings Account.....	7.60
December 31st, 1951—Balance to Credit of Account.....	<u>\$774.33</u>

BALANCE SHEET—DECEMBER 31ST, 1951

ASSETS		LIABILITIES AND FUNDS	
General Fund		General Fund	
Cash		Liabilities	
Maryland Trust Company.....	\$434.19	Designated Funds	
Petty Cash Fund.....	100.00	For Purchase of Dental Books.....	\$3.99
		For Library Account—Books and Journals.....	40.24
Due from John Ruhrah Fund—Consolidated Fund—Income Funds.....	5.73		\$44.23
		Withholding Tax—December, 1951.....	443.20
		Note Payable—Maryland Trust Company—Due on Demand—Interest at 3½% per Annum (Certain Securities of Consolidated Fund held as Collateral).....	6,000.00
		Total General Fund Liabilities.....	\$6,487.43
		General Fund Deficit.....	5,947.51
Total General Fund Assets.....	\$539.92	Total General Fund Liabilities and Deficit.....	\$539.92
Consolidated Fund—Income Funds		Consolidated Fund—Income Funds	
Cash		Liabilities	
Maryland Trust Company.....	\$20,054.50	Due to General Fund from John Ruhrah Fund.....	\$5.73
Undeposited Receipts—William F. Frick Fund.....	4.50	Due to Consolidated Fund—Principal Funds from Josiah S. Bowen Fund.....	629.30
Accounts Receivable—Baltimore City Medical Society.....	700.00	Total Consolidated Fund—Income Funds—Funds—Liabilities.....	\$635.03
Investments—Maryland Medical Service, Inc.....	5,050.00	Consolidated Fund—Income Funds Balances.....	25,173.97
Total Consolidated Fund—Income Funds—Assets.....	\$25,809.00	Total Consolidated Fund—Income Funds—Liabilities and Balances.....	\$25,809.00
Consolidated Fund—Principal		Consolidated Fund—Principal	
Uninvested Cash		Principal	
Held by Maryland Trust Company....	\$18.44	Designated Funds.....	\$137,776.75
Held by Mercantile Trust Company...	58.41		
Due from Josiah S. Bowen Fund—Consolidated Fund—Income Funds Investments (Market Value as of January 1st, 1946 and Additions at Cost).....	629.30		

United States Government and Municipal Bonds.....	\$39,230.85				
Public Utility and Railroad Bonds.....	19,788.25				
Preferred Stocks.....	10,446.75				
Common Stocks.....	103,474.42				
	<u>\$172,940.27</u>				
Less Reserve to bring Book Value of Securities down to Actual Cost....	35,869.67	\$137,070.60			
Total Consolidated Fund—Principal.....		\$137,776.75		Total Consolidated Fund—Principal.....	\$137,776.75
Funds Invested in Fixed Assets (No Depreciation Provided)				Funds Invested in Fixed Assets	
Real Estate—Cost				Principal.....	\$391,739.71
Property—1209-11-13 Cathedral Street—In Fee.....	\$110,635.76				
Annex Property—1215-17 Cathedral Street—In Fee.....	19,118.95	\$129,754.71			
Personal Property (Appraisal Figures at December 31st, 1949 and Additions at Cost)					
Library Books and Journals.....	\$231,370.00				
Office, Library, Household Fixtures, Antiques and Museum Pieces.....	16,615.00				
Portraits.....	14,000.00	\$261,985.00			
Total Funds Invested in Fixed Assets.....		\$391,739.71		Total Funds Invested in Fixed Assets—Principal.....	\$391,739.71
Forwarded.....		\$555,865.38		Building Fund	
Building Fund				Principal.....	\$54,369.05
Cash—First National Bank					
Checking Account.....	\$13,510.87				
Savings Account.....	5,552.17	\$19,063.04			
Investments—Cost					
United States Government Bonds.....	35,306.01				
Total Building Fund.....		\$54,369.05		Total Building Fund—Principal.....	\$54,369.05
Contingent Fund—Income				Contingent Fund—Income Balance.....	545.90
Cash—Maryland Trust Company.....	545.90				
Total Contingent Fund—Income.....		\$545.90		Total Contingent Fund—Income—Balance.....	\$545.90

Contingent Fund—Principal	
Investments—Cost	
United States Government Bonds.....	\$5,000.00
Common Stock.....	4,921.30
	<hr/>
Total Contingent Fund—Principal.....	\$9,921.30
Nellie N. Cowles Bequest Fund—Income	
Cash—Held by Maryland Trust Com- pany.....	25.00
	<hr/>
Total Nellie N. Cowles Bequest Fund— Income.....	\$25.00
Nellie N. Cowles Bequest Fund—Principal	
Investments—Cost	
United States Government Bonds.....	1,000.00
	<hr/>
Total Nellie N. Cowles Bequest Fund— Principal.....	\$1,000.00
Medical Annals Fund	
Cash—Union Trust Company of Mary- land.....	774.33
	<hr/>
Total Medical Annals Fund.....	774.33
	<hr/>
Total Assets.....	\$622,500.96
	<hr/>

Contingent Fund—Principal	
Principal.....	9,921.30
	<hr/>
Total Contingent Fund—Principal.....	\$9,921.30
Nellie N. Cowles Bequest Fund—Income	
Balance.....	25.00
	<hr/>
Total Nellie N. Cowles Bequest Fund— Income—Balance.....	\$25.00
Nellie N. Cowles Bequest Fund—Principal	
Principal.....	1,000.00
	<hr/>
Total Nellie N. Cowles Bequest Fund— Principal.....	\$1,000.00
Medical Annals Fund	
Principal.....	774.33
	<hr/>
Total Medical Annals Fund—Principal.....	774.33
	<hr/>
Total Liabilities and Funds.....	\$622,500.96
	<hr/>

GENERAL FUND—DEFICIT ACCOUNT

January 1st, 1951 to December 31st, 1951

January 1st, 1951—Balance to Debit of Account.....		\$5,719.20
<i>Additions</i>		
Excess of Expense Over Income—For Year Ended December 31st, 1951.....		4.46
Transfer to Consolidated Fund—Income Fund for 1950 Expenditures		
John Ruhrah Fund.....	\$300.00	
Osler Testimonial Fund.....	23.85	323.85
		<hr/>
		\$6,047.51
<i>Deductions</i>		
To set up Petty Cash Fund previously charged to Expense.....		100.00
		<hr/>
December 31st, 1951—Balance to Debit of Account.....		<u>\$5,947.51</u>

CERTIFICATE

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND,
1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND.

GENTLEMEN:

We have made a partial audit of the records in the office of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31st, 1951. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As a result of our work, we report to you, that in our opinion, the Exhibits, together with the comments in this report, present fairly the financial position of the Faculty as of December 31st, 1951, and for the year ended on that date.

Respectfully submitted,
WOODEN, BENSON & WALTON
Certified Public Accountants,
Members American Institute of
Accountants

COUNCIL

Mr. President and Members of the House of Delegates:

The Council, commencing with April 23, 1951, has met six times, and in the interim of these meetings the Executive Committee met five times. This latter Committee also had many telephone conferences when decisions had to be reached and the time element did not permit the calling of meetings. There was an average attendance of 21. The Council is composed of fifteen members and nine officers, etc., making a total of 24 members.

In many meetings, problems of the Library were discussed and the recommendations of the Library Committee were usually adopted. It was authorized that the Library is to be closed on Tuesdays and Thursdays at 5 p.m. until further notice. At this time I would like to extend the appreciation of the Medical and Chirurgical Faculty to Dr. A. C. Gillis, whose tenure of office on the Library Committee expired on December 31st, for his untiring efforts over these many years

on behalf of the Library while he so ably served as Chairman of the Committee. *I would like to recommend that this body take official action and that Dr. Gillis be so notified in a letter of appreciation, and that the same be incorporated into these minutes.*

During his Presidency, Dr. W. D. Wise was asked to appoint a Chairman of the Committee to cooperate with the American Medical Education Foundation, and Dr. Newland E. Day was appointed. The work of this Foundation was discussed at subsequent meetings.

It was deemed advisable to conform to the request of the Auxiliary to have two additional members on the Faculty Advisory Committee to the Woman's Auxiliary.

It was deemed inadvisable to prorate the dues for members who go into the Armed Forces, although after a member goes into the Service he is carried without payment of dues until he returns to active practice.

At the request of Governor McKeldin and in conjunction with the Baltimore City Medical Society, a Magistrates' Committee was appointed.

Due to the increased volume of work, the Council voted to discontinue the closing of the Faculty Building at 2 p.m. during the month of August.

Expenditures of funds for improving equipment and maintenance of the building was approved.

The Council regretted that it could not comply with the request of the Woman's Auxiliary for permission to use the Faculty seal on the Auxiliary stationery. This decision was reached after ascertaining the procedure in this matter by other State Medical Societies and after conferences with the attorney for the Faculty, Mr. G. C. A. Anderson.

The Committee on Constitution and By-Laws used the same procedures as indicated above and found that recognition of Woman's Auxiliary is not contained in the State Medical Society Constitution and By-Laws. The Council decided it would not be advisable to include the Woman's Auxiliary in the framework of its Constitution.

Due to the expenses encountered by the host component medical society at the Semiannual Meeting, it was the consensus of opinion that the Faculty should bear some of the expense. At this time, \$700 is allowed in the budget for the Annual Meeting, so Council suggested that \$400 be used for the usual expenses and \$300 be supplied by the Faculty to the host component society to help defray the cost; however, it is understood that additional expenses incurred should be borne by the local society.

Dr. Robert H. Riley called to the attention of the Council that physicians are billing patients for laboratory diagnostic work performed by the State Health Department. This problem came under the province of the Advisory Committee to the State Department of Health.

The House of Delegates at its September meeting, on recommendation of the Council, places the names of the following physicians on the list of emeritus members:

Dr. E. E. A. Dunn, Bethesda, Maryland
Dr. H. H. Howlett, Silver Spring, Maryland
Dr. Charles L. Owens, Cumberland, Maryland
Dr. Maurice E. E. Owens, Cumberland, Maryland
Dr. John W. Baylor, West Chester, Pa., member of
Baltimore City Medical Society
Dr. Joseph V. Castagna, Baltimore City
Dr. Ira W. Beall, Libertytown, Maryland
Dr. Otis B. Stone, Libertytown, Maryland

Mr. G. C. A. Anderson, the incumbent counsel for the Faculty, was again asked to act in this capacity for the Faculty and accepted.

Questions arising as to incorporating certain subjects in the Constitution and By-Laws was referred to the Committee on this subject, of which Dr. L. R. Wharton is Chairman. In every instance a study was made and the recommendations of the Committee were reported to the Council. The Council deemed it advisable to have the Chairman of the Committee on Constitution and By-Laws serve as an ex officio member of the Council so that he may be familiar with the functioning of the Association, and it is requested that the House of Delegates approve of this action of the Council. Dr. Wharton has

attended several of the meetings and this seems to be a valuable procedure.

The Committee on Constitution and By-Laws was also asked by the Council to make a study and recommendations as to the advisability of having a Reference Committee. Dr. Wharton reported that many state medical societies and the A. M. A. have such committees to whom resolutions are referred prior to final action by the governing body of the organization, which for the Faculty would be the House of Delegates. The amendment to the Constitution and By-Laws on the appointment of such a committee suggested by Dr. Wharton was approved by the Council and will be acted on at this Annual Meeting by the House of Delegates.

Two of the symposia—*Drug Addiction* and *The Doctor in Court*—given under the auspices of the Joint Medical Legal Committee of the Bar Association and the Medical and Chirurgical Faculty, of which Dr. Louis Krause is the Faculty Chairman, were authorized for publication in the Maryland State Medical Journal. Other symposia are being planned by this Committee. These meetings have been held in Osler Hall.

As a result of one of the above mentioned symposia, the Council considered the following recommendation made by Dr. Thomas C. Wolff in his address during *The Doctor in Court*:

"That a properly classified panel of such EXPERT MEDICAL WITNESSES be nominated by the Medical Society for short periods of service, to be replaced by another such panel when the period of service has expired, and that the Doctors on such panels reply to calls for such service as a matter of civic obligation."—*Doctor in Court Symposium* under auspices of Medicolegal Committee held in Osler Hall, Friday, December 7, 1951.

The Chairman of the Council was authorized to appoint a Committee to make such a study. However, before the instructions of the Council could be fulfilled, it was necessary to have the cooperation and assistance of the lawyers. Subsequently the President of the Bar Association, Mr. John S. Stanley, has been contacted and until his wishes are known on the subject, the Chairman of the Council is holding the appointment of a Committee in abeyance.

The Annual Meeting dates were set for Tuesday, April 29 and Wednesday, April 30, 1952, with the Special Sessions of the House of Delegates on Monday, April 28.

Dr. Otto Schaefer has been placed on the list of Fifty Year Members, which gives him all the privileges of active membership without payment of dues.

Dr. William A. Garlick was appointed Chairman of a Committee which investigated the problems of allocation of insurance benefits to hospitals for their respective physicians. The report was accepted and a copy was sent to each hospital asking that this report be used as a basis for settling its own problems in allocating the funds from insurance companies. The funds are not to be used for the running of the hospitals, but are to be used, in accordance with the report, for research, postgraduate education, benefits of house staffs, etc. This was duly seconded and carried.

On November 27, 1951, Dr. Goldstein attended the Council

meeting and explained about the trouble the Building Fund Committee is having in securing funds. Suggestions were made to him but no concrete action on the part of the Council was requested by Dr. Goldstein. At a recent meeting of the Building Fund Committee, Dr. Goldstein requested renewed activities.

Mr. G. C. A. Anderson attended the Council meeting on February 19, 1952, and made suggestions regarding one of the cases before the Professional Conduct Committee.

At the same meeting the interpretation of various sections of the Medical Practice Act were discussed by Mr. Anderson, Mr. J. E. Harvey, Deputy Attorney General for Maryland, and particularly with reference to revocation of licenses.

Doctors E. H. Kroman and L. P. Gundry, President and Secretary respectively, of the Board of Medical Examiners also met with the Council. The Council adopted the following resolution:

This Council is in full support of the Board of Medical Examiners in their action in taking the licenses away from physicians convicted in Court of income tax evasion, and further desires that this support by the Council be published in the Maryland State Medical Journal.

The Council recommended that the Secretary of the Faculty, upon notification from the Board of Medical Examiners of its revocation of a license, notify the member of his loss of membership in the Medical and Chirurgical Faculty and that he has the privilege of reapplying for membership upon renewal of his license. A copy of this letter is to be sent to the Secretary of the Component Medical Society of which the physician, whose license has been revoked, is a member.

Beginning in November, 1951, it was deemed advisable to have dinner meetings. As there is an increased amount of business this may very easily be covered by meeting at 4 p.m., adjourning at 6 p.m., for dinner, and reconvening immediately after dinner. It was also felt that this might be a method of having less Council meetings and making it easier for the members coming from the Component Medical Societies. To date, these meetings have been quite successful.

The Council tabled the request from the A. M. A. that publicity be given as to the availability of a plaque for use in doctors' offices in connection with the promotion of better understanding between the patient and doctor.

Mr. Kirkman's budget for 1952 was approved, and the Council expressed their appreciation to him for this fine report.

During the past year Physician's Defense has been requested and granted to six members.

Subjects pertinent to Component Medical Societies were referred to Council for discussion and, if necessary, specific action was taken.

The Professional Conduct Committee referred several cases for final action to the Council.

It was the consensus of opinion of the Council that if the Professional Conduct Committee is to be effective, letters of complaint received in the Faculty office should be referred to it and not to the Component Medical Societies.

The Council ruled that the regular membership addressograph file, which contains the addresses given by the members

for receipt of mail, should be used for sending out the Journal and not the "Dr. and Mrs." one which contained the home addresses.

Due to the decrease in the number of members of the Faculty paying A. M. A. dues, the allocated delegates to represent the Faculty in the A. M. A. House of Delegates is two instead of three. The delegates representing the Faculty are Doctors J. W. Bird, Warde B. Allan and John W. Parsons. Dr. Bird suggested to the Chairman that he would relinquish his position as it was time for the younger men to assume some of the responsibilities and that Doctors Allan and Parsons be the two delegates to represent the Faculty. In compliance with Dr. Bird's suggestion, the Chair requested Doctors Allan and Parsons to continue as delegates. At this time I would like to express the appreciation of the Medical and Chirurgical Faculty to Dr. J. W. Bird for serving over a period of many years as one of Maryland's delegates and for so ably representing the Medical and Chirurgical Faculty in the House of Delegates of the A. M. A.

There is much memorabilia in the possession of the Faculty and suitable locations should be found for these portraits, photographs, old medical instruments, etc. The Council requested Dr. J. A. Chatard to serve as Curator and he has consented. Dr. Chatard may select a committee to help him.

Dr. William F. Williams was appointed one of the Vice-Presidents to serve in Dr. W. A. Gracie's (deceased) place until the meeting of the House of Delegates in April 1952.

Mr. R. E. Dabney, Dr. Richard F. Kieffer, and Dr. Hugh J. Jewett reviewed the experiences of Blue Shield and set forth several suggested changes. The Council approved these changes and final action is to be taken by the House of Delegates. The Secretary was instructed to send to the Presidents and Secretaries of the Component Societies, and the Delegates, complete data so that they may be informed prior to meetings of the House of Delegates.

A preliminary study on enlarging the size of the Bulletin was recommended on May 23, 1951, with the result that after discussions of the subject at subsequent meetings the decision was reached and the recommendation made to the House of Delegates in September, 1951, which has resulted in the publication of the Maryland State Medical Journal. The credit for this Journal is due to Dr. George H. Yeager who has continued to carry on the duties of Secretary of the Faculty, plus the onerous task of Editor of the Journal. Resolved that:

The Medical and Chirurgical Faculty expresses its gratitude and sincerely thanks Dr. George H. Yeager for his untiring efforts as Secretary of this Association and Editor of its new publication THE MARYLAND STATE MEDICAL JOURNAL.

The following members are recommended for emeritus membership:

Dr. Frances E. Weitzman, Annapolis
 Dr. DeWitt B. Casler, Baltimore City
 Dr. Karl W. Ebeling, Baltimore City
 Dr. Edgar B. Friedenwald, Baltimore City
 Dr. Howell I. Hammer, Baltimore City
 Dr. Roy W. Locher, Baltimore City
 Dr. Harry D. McCarty, Baltimore City

Dr. Fuller Nance, Baltimore City
 Dr. Edwards A. Park, Baltimore City
 Dr. Howard Tonolla, Baltimore City
 Dr. A. McC. Stevens, Easton

Respectfully submitted,
 C. REID EDWARDS, M.D., *Chairman*

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

The Fifth Annual Interim Session of the American Medical Association held in Los Angeles, December 4, 5, 6 and 7, 1951, was highly successful. The business of the House of Delegates was not heavy. The attendance exceeded that of any of the previous Interim Clinical Sessions. One hundred and eighty-two delegates were present. A detailed account of the meeting can be obtained by reading the American Medical Journal where a complete report is submitted. I will attempt to submit the following items which may be of interest to the members of the Faculty.

Public Relations Conference

The Fifth Annual Public Relations Conference was held on December 2 and 3, 1951, prior to the meeting of the House of Delegates. I arrived the morning of December 3rd and attended the second day session. Emphasis was placed on certain facts which should be of importance to physicians. Among them were: the importance of Medical Societies joining forces with other groups; physicians being represented on a national level; State Medical Societies joining forces with organizations on a State-wide basis; the doctor in community affairs; what the County Society can do in public relations, and the importance of the individual physician's role in such a program. Great emphasis was placed on a closer relationship between the patient and the doctor. The low cost of physician's service as compared with that of forty years ago should be emphasized. We have tried to improve the standard of medical care and hospital standards but patients are not informed of these facts. There was a definite feeling that the American Medical Association should consolidate efforts with other National organizations. The relationship between hospitals and physicians should be improved. A National Committee has been appointed composed of representatives of the American Medical Association, the American College of Surgeons, the American Hospital Association and the American College of Physicians with possible Canadian Representation to standardize hospitals. It is important to inform Women's Organizations of our program and guide their services both in State Societies and in the County Societies. There is a latent power in the Women's Auxiliaries that is unbelievable. They have tremendous power and will do everything possible to emphasize the program of the National, State and County Organizations. It was suggested that we have a liaison officer to operate between the State Society and the Women's Auxiliaries.

How the House of Delegates of the A. M. A. is Set Up

The House of Delegates of the American Medical Association is truly representative of the nation's doctors. Its policies are shaped from the ground up. Its decisions are developed democratically. Component county societies elect delegates to form the House of Delegates of their state associations. The membership of the county societies which are the individual practicing physicians, use the forum of their county society meetings to formulate opinion and policy. They vote upon policy decisions and the majority rules as in all democratic procedure.

Delegates to the State Association represent their county societies in arriving at state association opinion and policy. The constituent State associations in turn offer resolutions which express their will at the annual and interim sessions of the House of Delegates for action by the House.

These resolutions are referred to one of fourteen reference committees, each of which is made up of a chairman and four other members of the House of Delegates.

A total of 70 members of the House serve on these reference committees out of a total membership in the House of 202 delegates.

Reference committees are appointed by the Speaker of the House. Each year the chairman and the composition of the reference committees change so as to obtain maximum democracy in committee hearings and recommendations to the House.

The reports of the committees are then made to the House. The House debates these reports, votes upon them, and the majority rules.

The voted actions of the House become the official policy of the American Medical Association, and prevail until they are changed by further action.

These policies represent as democratically as possible the opinions and wishes of the entire A. M. A. membership.

Abstract from the Address of the President

JOHN W. CLINE, M.D.

Scientific medicine in the United States has progressed to a point never reached before any place in the world. Our standards of medical education and medical care have never been equaled, and these are the developments wrought by a free profession and educational institutions unhampered by governmental control. The principal problem has been and, to a large extent, remains the best means of distributing these advantages to all the people. In the main the approach is through voluntary health insurance. The growth and development of plans offering this coverage has been gratifying. When one realizes the short space of time in which this has been achieved it must be considered to represent satisfactory progress.

More than 77,000,000 persons now have some coverage against the cost of illness. About 22,000,000 are enrolled in Blue Shield and other medically sponsored plans, and 44,000,000 are enrolled in Blue Cross plans. This growth has been phenomenal. More than half our population has protection from the economic hazards of illness. On the other hand, we must not only expand the numbers enrolled but improve

our plans. The exact direction the improvement should follow is not equally clear. As of this time, no one can say what will constitute the most desirable coverage in the future. The multiplicity and diverse nature of the plans creates a healthy situation. The very elasticity of the programs permits and encourages experimentation. The orderly process of evolution will produce a form that at some future date will be generally agreed on as embodying the most nearly ideal type of coverage. This process will not be limited by the legal enactments or the arbitrary decisions of governmental agencies inherent in any scheme of socialized medicine.

Report of Campaign Coordinating Committee

ELMER L. HENDERSON, M.D.

Three years ago, on December 1, 1948, in a momentous session at St. Louis, which should long be remembered by every doctor who values his right to practice in freedom, this House of Delegates adopted a Statement of policy which may well be called American Medicine's Declaration of Independence.

It was a ringing declaration of belief in medical responsibility, and in voluntary action as opposed to compulsion, in meeting the problem of providing prepaid medical care for the American people. It was a forthright declaration, too, that American medicine would fight to defend and maintain its freedom.

This Committee, which had been directed to organize and supervise the National campaign of public education, met and worked for months in a continuous state of emergency—and there were many who told us that we had started too late; that we should have bowed to the inevitable and sought a compromise with those in the Government who were determined to take over the control of medical practice.

On this third anniversary of medicine's Declaration of Independence, it is important that we make realistic appraisal of what we have achieved, in order to be very sure of where we stand today, and what should be our course for the future.

Perhaps the most significant figures which could be cited in this report are the most recent compilations of the Americans who are protected today under Voluntary Health Insurance. These figures furnish the most conclusive proof of medicine's conviction that "the voluntary way is the American way." The latest figures disclose that in the three years since our Nationwide campaign of education was launched, there have been 25,000,000 additional enrollments in the Voluntary Health Insurance plans of the country—and that today approximately 77,000,000 people in the United States have some form of prepaid health protection.

As Members of the House are aware, the present National Administration is expected to make vigorous renewal of its demand for Compulsory Health Insurance legislation in the first month of the coming session of Congress. It should also be noted that Governor Earl Warren of California, a declared candidate for the Republican nomination for President, recently has renewed his agitation for Compulsory Health Insurance.

We must maintain the interest and the friendly cooperation

of the many thousands of organizations whose support we have won in our campaign against regimentation.

It is apparent that Americans expect such help and such leadership in their home communities, from doctors who have led the three-year crusade to turn the edge of socialism.

During the months ahead, this Committee intends to urge doctors to exercise their precious privileges as alert and responsible citizens. Every doctor will be meticulously advised that his medical society, as an incorporated organization, *must not participate in election activities*. But every doctor will be as carefully advised as to *what he may do legally*, as an individual citizen who cares about the course of his country, to help determine that course.

Whitaker and Baxter have been retained on a half-time counselling basis to direct this work.

This we believe to be the only appropriate culmination to the work of preserving the freedom of the medical profession—and at this crucial time in American affairs, we believe this to be the greatest contribution we can make to our country.

Medical Schools Get \$500,000 from A. M. A.

The American Medical Association has contributed another half million dollars to the American Medical Education Foundation, which has been raising funds within the medical profession, during the last year for the unrestricted use of the nation's medical schools.

The Foundation was founded at the December, 1950, meeting of the American Medical Association in Cleveland at which time the Board of Trustees announced an appropriation of half a million dollars as the nucleus of a fund to be raised by the medical profession to assist medical schools.

Since then, an additional \$250,000 has been contributed by national, state and local medical societies and through individual donations.

In making the second contribution, Dr. Dwight H. Murray, Napa, California, chairman of the A. M. A. Board of Trustees, told the House of Delegates that the A. M. A. wishes to underscore the importance of this voluntary campaign to raise funds for medical schools. He said: "We are hopeful that techniques will be developed and actions taken that will assure a substantial flow of funds from voluntary sources to the medical schools each year that will significantly assist the schools to meet the financial problems they face."

Committees on the Blood Bank

Report on the Committee on the blood bank was very detailed and can be found in the Journal dated December 22, 1951.

Guides for Conduct of Physicians in Relationship with Institutions

This is a subject that has been discussed and considered at all meetings of the House of Delegates since 1949 and the Board of Trustees has these reports under study.

In summary, the following general principles are suggested to individual physicians, county medical societies and state medical associations as a basis for adjusting controversies, to

the extent required by the applicability of one or more of the factors heretofore mentioned:

1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

2. Where the hospital is not selling the services of a physician, the financial arrangements if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for these purposes.

3. The practice of anesthesiology, pathology, physical medicine or radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine.

Respectfully submitted,
J. W. BIRD, M.D., *Delegate*

Mr. President and Members of the House of Delegates:

The meeting in June in Atlantic City was well attended. The scientific program and scientific exhibit were of a superior nature. A great deal of business was taken up in the House of Delegates. Of interest is the fact that the Distinguished Service Award was given to Dr. Allen O. Whipple.

It was announced that a new Commission on Creditation of Hospitals was formed which was to consist of members of the American College of Surgeons, American College of Physicians, American Hospital Association, American Medical Association, and one member from the Canadian Medical Association. It is of interest to most members, that efforts are still being made to have expenses incurred by doctors in taking post graduate courses to be exempt from income tax. Efforts are also being made to persuade Congress to allow some form of "pension" for the physicians.

Less stress than usual was made regarding the campaign against the Federal Health Program. Encouraging reports on Voluntary Health Insurance plans were announced. A great many resolutions were presented regarding a great variety of matters including setting up Residencies in General Practice, and resolutions on simplifying and standardizing the reporting of health and accident cases. The resolution for the abolishment of Fellowships in the American Medical Association has still to be clarified. The election of officers took place at this meeting and Dr. Louis Bauer is the President-Elect.

Respectfully submitted,
WARDE B. ALLAN, M.D., *Delegate*

Mr. President and Members of the House of Delegates:

I attended the June 1951 meeting of the American Medical Association in Atlantic City. The results of this meeting are fully reported in Dr. Bird's and Dr. Allan's reports. I have nothing to add, and concur in the reports as submitted.

Respectfully submitted,
JOHN W. PARSONS, M.D., *Delegate*

BOARD OF MEDICAL EXAMINERS OF MARYLAND

Mr. President and Members of the House of Delegates:

The Board of Medical Examiners is composed of the following members:

Dr. John E. Legge, (1952)
*Dr. E. Hanrahan, (1952)
Dr. Henry T. Collenberg, (1953) *Vice-President*
Dr. E. Paul Knotts, (1953)
Dr. Lewis P. Gundry, (1954) *Secretary*
Dr. Edward P. Thomas, (1954)
Dr. Erasmus H. Kroman, (1955) *President*
Dr. John H. Hornbaker, (1955)

The terms of Dr. Legge and Dr. Hanrahan will expire on June 1, 1952, therefore two members to serve until June, 1956, are to be elected at this Annual Meeting of the Medical and Chirurgical Faculty.

Examinations held during the year show the following results:

Number examined for license.....	189
Number passed.....	173
Number failed.....	16

Of the 16 who failed, 15 were graduates of foreign medical schools, one was a Chinese graduate of Woman's Medical College in Philadelphia.

Licenses issued after examination.....	173
Licensed by reciprocity with other States.....	70
Licensed by recognition of National Board certificates.....	51

Total licenses issued in 1951.....	294
------------------------------------	-----

Licenses revoked.....	5†
Licenses restored after revocation.....	1

The following certificates were also issued:

Certification to other States.....	201
Borderline certificates (D. C.).....	56
Copies of license issued.....	8
Miscellaneous certificates.....	17

During the year 1951, graduates of foreign medical schools were considered as follows:

Written inquiries answered.....	223
Interviews (office) approximately.....	150
(average 3 each week)	

*Dr. Hanrahan has been on leave of absence, on account of illness, since November 1, 1951. Dr. Samuel McLanahan was elected by the Board to serve the unexpired term of Dr. Hanrahan.

†Four licenses were revoked following conviction, in the Federal Court, of Income Tax evasion. One of these licenses has been restored. One license revoked on conviction of aiding in an abortion.

Foreign credentials reviewed.....	42
Foreign-approved for examination.....	32
Foreign graduates examined.....	32
Passed.....	17
Failed.....	15
Foreign inquiries (written) since January 1, 1952.....	77

The policy of this Board with reference to graduates of foreign schools has been to accept graduates of foreign medical schools which are on the approved list of the American Medical Association and the Association of American Medical Colleges, and also graduates of those European medical schools which were known to be acceptable prior to January 1, 1940. No graduates of European medical schools not on the approved list, who graduated subsequent to January 1, 1940, are accepted.

Graduates of foreign medical schools are not admitted to license by reciprocity, or in recognition of National Board Certificates.

The Board of Medical Examiners has continued to cooperate with the Professional Conduct Committee of the Medical and Chirurgical Faculty.

Respectfully submitted,

LEWIS P. GUNDRY, M.D., *Secretary*

N. B. in re

STATE PRACTICE ACT

State Board of Medical Examiners—Henry T. Collenberg, Edward M. Hanrahan, John H. Hornbaker, Erasmus H. Kloman, E. Paul Knotts, John E. Legge, Edward P. Thomas, Lewis P. Gundry, Secretary, 1215 Cathedral Street, Baltimore 1, Maryland.

Meetings of the Board of Medical Examiners of Maryland—The regular meeting is held the first Tuesday in June and other meetings are held about four times a year at such times as the discretion of the Board may determine. Special meetings are held from time to time to consider particular policies or problems.

Regular Examinations—Examinations are held in Baltimore, the third Tuesday in June for four consecutive days and the second Tuesday in December for four consecutive days.

Reciprocity or Endorsement Information—The license of the Board of Medical Examiners of Maryland is recognized for license without examination in the following States: Alabama, Arkansas, California, Connecticut, Delaware, District of Columbia, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wisconsin.

Diplomates of the National Board of Medical Examiners are also admitted to license without examination.

Information connected with Medical Examinations and licensure by addressing the Secretary, 1215 Cathedral Street, Baltimore 1, Maryland.

LIBRARY COMMITTEE

Mr. President and Members of the House of Delegates:

The Library Committee has been meeting regularly during this year. It regrets the loss of its Chairman, Dr. Andrew C. Gillis, whose tenure of office expired in December, 1951. The present Committee is striving to continue the good work of the past and hopes that it might be able to increase the scope of its activities. Our meetings are well attended; in addition there are many occasions in which the individual members of the Committee are called upon to do additional library activities.

The library now consists of seventy-five thousand, five hundred sixty-two books and in addition about fifteen thousand duplicates. This, of course, does not include the numerous pamphlets, reprints and unbound publications. There are duplicate files of many journals and plans are being made according to the recommendations of the Faculty to utilize these duplicates in one or two of the medical libraries elsewhere in the State of Maryland. The donations of books and journals are still being received both from many of our active members as well as from the estates of former members. We are always happy to receive these donations since frequently they complete some of our files and we are also able to direct them into places where they can be best utilized.

I think without a doubt the library is now reaching a position of merit owing to the ability and activities of Miss Pauline Duffield, the Librarian, and her assistants. It is to be regretted, however, that adequate help is very difficult to get. This, of course, places a greater burden upon the few who are carrying the load. I wish to emphasize that our Library Staff has been supplying a tremendous amount of information to hospital staffs and individual members in the preparation of many of their publications. This year has also added an additional burden with the publication of the Faculty Journal.

The library, however, continues to be used by many of our members and quite extensively by some. I believe this will increase as time goes on. It is my impression that there is greater enthusiasm reflected in the importance of the library as a result of the upsurge of interest in our regular monthly meetings. This is interpreted as a very healthy sign and we hope that it forbodes a brighter future.

The statistical report follows below.

Respectfully submitted,

LOUIS KRAUSE, M.D., *Chairman*

LAWRENCE R. WHARTON, M.D.

SAMUEL WOLMAN, M.D.

JOHN T. KING, M.D.

A. AUSTIN PEARRE, M.D.

C. CLIFTON COWARD, D.D.S.

LIBRARY REPORT

1951

Circulation.....	6,598
Books used in Library.....	3,870
Total of books used.....	10,468

LIBRARY REPORT—Continued

Books added.....	393
Journals added.....	440
Total volumes in library.....	75,562
(15,000 are duplicates)	

Attendance.....	3,993
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Medical Library Association Exchange

Issues sent.....	3,476
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Cards Added to the Card Catalogue

Library of Congress Cards.....	640
Typed Cards.....	2,024
Shelf List.....	864
Added Information.....	300
Collections.....	100
Total No. of Cards.....	3,928

Binding

Journals Bound.....	440
Total Cost.....	\$1,373.85
Average Cost Per Jr.....	\$3.10

Requests from County Members.....	58
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Gifts

Reprints.....	884
Pamphlets & Reports.....	255
Unbound Journals.....	10,655
Bound Journals.....	261
Books.....	240
Clippings.....	100
Book Plates.....	2
Pictures.....	1

Total Gifts.....	12,398
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Petty Cash Report

Received from office & fines.....	\$132.20
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Transportation of Books.....	35.94
Postage and Express.....	67.99
Supplies, etc.....	23.28

Balance on hand.....	\$4.99
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Inter-Library Loans

Loaned

Aberdeen.....	7
Oak Ridge National Lab.....	1
University of Connecticut.....	2
Maryland General Hospital.....	4
Med. College of S. Carolina.....	2
Johns Hopkins University.....	5

West Virginia University.....	20
Amherst College.....	1
Univ. of North Carolina.....	1
Sheppard Pratt Hospital.....	5
State Dept. of Health.....	4
Social Security Library.....	2
Baltimore City Health Dept.....	11
Sinai Hospital Library.....	22
St. Agnes Hospital.....	1
Univ. of Md. (College Park).....	1
Univ. of Md. Med. Library.....	10
Welch Medical Library.....	39
Fort Howard.....	19
Mercy Hospital.....	2
Notre Dame.....	7
U. S. Marine Hospital.....	1,344
Total.....	1,510

Borrowed

University of Alabama.....	1
Inst. of Living.....	1
Vanderbilt University.....	1
Pratt Library.....	1
Provident Hospital.....	1
Sinai Hospital Library.....	1
Univ. of Maryland.....	11
Welch Medical Library.....	26
Army Medical Library.....	6
Univ. of Minnesota.....	1
U. S. Marine Hospital Library.....	1
Peabody Library.....	1
Total.....	52

LIBRARY OF THE MEDICAL AND CHIRURGICAL FACULTY

GIFTS FOR 1951

NAME	REPRINTS	PAMPHLETS AND REPORTS	JOURNALS	BOUND JOURNALS	BOOKS
Abbott Laboratories Library.....			1		
Abeshouse, Benj. S. (2 bk. plates).....	4				
Agramonte Memorial Library.....			53		
Agricultural Experiment Station.....			1		
American Cancer Society.....					6
American College Surgeons.....					1
American Dental Association.....					1
American Laryn. Association.....		1			
American Medical Association.....					1
American Surgical Association.....		1			
Andrus, E. Cowles.....					7
Anson, Dr. Barry J.....	33				
Archibald Church Library.....			8		
Army Medical Library.....			104		

LIBRARY GIFTS—Continued

NAME	REPRINTS	PAMPHLETS AND REPORTS	JOURNALS	BOUND JOUR- NALS	BOOKS
Association of Am. Physicians.....		2			
Austrian, Dr. C. R.....			106		1
Baltimore City, Dept. Public Wel- fare.....		1			
Bagley, Jr., Dr. Charles.....			204		
Beck, Harvey G. (100 clippings)					
Boston City Hosp. Med. Lib.....			1		
Boston Medical Library.....			6		
Boston Univ. Sch. of Med. Lib.....			3		
Boyd, C. Holmes.....			108		
Brady, Dr. Leo.....			34		
Brantigan, Dr. Otto C.....			34		
Bridges, Dr. W. A.....			87		
Bristol Laboratory Inc. (1 picture)					
Carl Boettiger Memorial Lib.....			12		
Carnegie Inst. of Washington.....			1		1
Charlotte Medical Library.....			1		
Chatard, Dr. J. A.....			91		1
Children's Hosp. of Michigan.....			1		
Christ Hosp. Med. Research Library			13		
Cleveland Medical Library.....			12		
Coggins, Dr. Jesse.....			120		
Columbia Univ., Dept. of Pediat- rics.....	14				
Comm. of Health (B. C. H. D.)....		1			
Copeland, Dr. Murray M.....	1				
Corner, Dr. George W.....				1	
Cowen, David L.....	1				
Creighton Univ. Sch. of Med.....			8		
Dunton, Dr. W. R.....			126		1
Dept. of Public Improvement (Md.)		1			
Enoch Pratt Free Library.....					1
Federal Trade Commission.....		1			
Feldman, Jr., Dr. Maurice.....			16		
Fleck, Dr. H. K.....		1			
Fox, Dr. Samuel.....			100		
Friedenwald, Dr. E. B.....	348		950	65	
Georgetown University Library....			1		
Geraghty, Dr. F. J.....			59		
Gillis, Dr. A. C.....			259		60
Gundry, Dr. Alfred.....			487		
Hahnemann Med. Coll. Library....			8		
Henderson, M., Hoagland Lib.....			1		
Herbert Cox Shoes.....		1			
Hogan, Dr. John F.....	339		1066		
Howard, Dr. J. T.....			206		
The Human Betterment League....					2
Humpton, Miss B. O. & Jane.....					19
Hundley, Dr. J. M.....			150		
Julius Hyman & Co.....		1			
Hynson, Westcott & Dunning.....			31		

LIBRARY GIFTS—Continued

NAME	REPRINTS	PAMPHLETS AND REPORTS	JOURNALS	BOUND JOUR- NALS	BOOKS
Inst. Study of Anal. & Sed. Drugs..		1			
State Univ. of Iowa Med. Library..			11		
Johnson, Dr. Adrian.....			1		
Kimberly, Dr. Robert C.....			95		
Knox, III, Dr. J. H. M.....			170	14	
Knoxville Academy of Medicine...			2		
Koontz, Dr. A. R.....			226		
Krause, Dr. Louis.....			690		
Kress, Dr. Milton B.....			36		
Lab. del Norte de Espana, S. A....	5				
Lane Medical Library.....			22		
Leborgne, Raul.....	2				
Lederle Lab. Inc., Library.....			4		
Lee Foundation for Nut. Research..					1
Leutscher, Dr. J. A.....	100		15	6	
Lewison, Dr. Edward F.....			100		
Library, Union Mem. Hosp.....			200		
Lilly Research.....			1		
Los Angeles Co. Gen. Hosp.....			5		
Los Angeles Co. Med. Assoc. Lib...			6		
Louisiana St. Univ. Med. Lib.....			2		
McGavack, Dr. T. H.....	6				
McKenzie, Dr. W. R.....	3				
McLanahan, Dr. Samuel.....			479		
Macht, Dr. David.....					1
Mandabach, Dr. G. B.....	1				
Mansdorfe, Dr. G. B.....			90		
Mass. General Hospital.....			31		
Maxson, Dr. C. W.....			92		
Mayo Clinic Library.....			53		
Med. Coll. of Alabama.....			2		
Med. Coll. of South Carolina.....			20		
Medical Coll. of Virginia.....		1	109		
Med. Lib. of Ky.....			1		
Merck & Co.....		1			
Miller, Mrs. Sydney.....			154		
Ministerio Da Ed. E. Saude.....					1
Moore, Dr. J. E.....			898		5
Morrison, Dr. Samuel.....			9		
Morrison, Dr. T. H.....			15		2
Municipal T. B. Library, Chicago..					1
National Dairy Council.....	2				
Nat. Found. for Infantile Paralysis.		1			1
New Brit. Gen. Hosp. Lib.....			2		
New Rochelle Hosp. Library.....			1		
N. Y. Academy of Med. Library....			6		1
Northwestern Univ. Med. Library..					1
O'Donovan, Dr. C. (Jr.).....				128	14
Padget, Mrs. Paul.....			97		
Parry, A. C.....					1
Pfizer, Charles & Co.....					3

LIBRARY GIFTS—Continued

NAME	REPRINTS	PAMPHLETS AND REPORTS	JOURNALS	BOUND JOURNALS	BOOKS
Phipps Clinic.....			19		
Rockefeller Foundation.....	9				
Rockefeller Inst. for Med. Research.....		4			2
Royal College of Physicians.....					2
Ruch Med. College Library.....					2
St. Joseph Hospital.....			123		
San Diego Co. Med. Library.....			1		
Sands, Dr. James.....			65		
Schapiro, Dr. W. B.....			71		10
Seliger, Dr. Robert V.....	10				5
Sheppard Pratt Library.....	61		316		4
Shamer, Dr. M. E.....			52		
Shealy, Dr. W. H.....			99		
Simmons, Dr. J. S.....	2				
Sinai Hosp. Library.....			1		
Smith, Kline & French Lab.....					1
Sofield, Dr. H. A.....					1
Sonnenfeldt, Dr. Gertrude.....			62		
Sonnenfeldt, Dr. W. H.....			54		
Southwestern Medical School.....			2		
Squibb & Sons.....			24		
State of La. Dept. of Health.....		1			
St. Univ. of N. Y., Library.....			19		
Stone, Dr. H. B.....				43	
Think.....					1
Thorek, Dr. Philip.....	13				
Toledo Med. Library Assn.....			2		
Toulson, Dr. W. H.....	1		48		
Tredwell Library.....			12		
Trimble, Dr. I. Ridgeway.....			22		

LIBRARY GIFTS—Continued

NAME	REPRINTS	PAMPHLETS AND REPORTS	JOURNALS	BOUND JOURNALS	BOOKS
Tuberculosis Assn. of Pierce Co.....			1		
Tulane Med. Library.....			1		
U. S. Marine Hospital.....	6				1
Univ. Bibliothek Gottingen (<i>theses</i>).....		128			
Univ. of Chicago.....			65		
Univ. of Ill. Med. Library.....			185	4	
Univ. of Michigan Med. Lib.....			1		
Univ. of Okla. Med. Library.....			4		
Univ. of Rochester Med. Lib.....			9		
Univ. of Tennessee Med. Library.....			1		
Univ. of Texas Med. Lib.....			4		
Univ. of Utah Med. Library.....			1		
Univ. of Wisc. Med. Library.....			18		
Unknown.....			36		
Upjohn Co.....					1
Vanderbilt Univ. Med. Library.....			3		
Veterans Adm. Center, Kansas.....			1		
Veterans Adm. Hosp., Albany, N. Y.....			7		
Washington Inst. of Med.....			1		
Wells, Dr. G. J.....			236		
W. Va., St. Med. Assn.....		1			
Wharton, Dr. L. R.....			77		
Williams & Wilkins.....					74
Wiscott, Mr. W. J.....			516		
Wise, Dr. W. D.....			21		
Wolf, Dr. F. S.....			8		2
Wolman, Dr. Samuel.....			162		
Worsley, Dr. T. J. (Jr.).....			185		
X-Ray Mfg. Corp. of America.....		1			
Yeager, Dr. G. H.....			7		

TOTAL GIFTS

1951

Reprints.....	884
Pamphlets & Reports.....	255
Journals.....	10,655
Bound Journals.....	261

Books.....	240
Clippings.....	100
Book Plates.....	2
Pictures.....	1

COMMITTEE ON SCIENTIFIC WORK AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

It may be of interest to the members of the Medical and Chirurgical Faculty to know that the registration at the 1951 Annual Meeting was 745, and 300 attended the buffet supper.

Last year the Semiannual Meeting was held in Ocean City

and there was a great deal of enthusiasm in regard to having our meetings more often in this locality. Following on pages 406 and 407 is the program, which contains the scientific sessions and other features of the meeting. Registration was 322, and 276 lunches were served.

It has been recommended by the Council that \$300.00 be supplied by the Faculty to the host Component Society to help defray the cost of the Semiannual Meeting, but that addi-

(Continued on page 408.)

1951**PROGRAM OF THE SEMIANNUAL MEETING****1951****Headquarters****ATLANTIC HOTEL, OCEAN CITY, WORCESTER COUNTY, MARYLAND***

* See "Notes" (below).

Friday, September 14, 1951**REGISTRATION—9:00 a.m.****Lobby, Ocean Entrance**

(All the members and their guests are urged to register so that an accurate record may be kept of the attendance.)

Those who arrive on September 13th may register on Thursday from 7:30 p.m. to 9:30 p.m.

BUSINESS SESSIONS**Council Meeting—9:30 a.m.****Sun Porch, Main Floor, Southeast Wing****House of Delegates—10:30 a.m. to 12 noon****Ballroom, Main Floor, North Wing****LUNCHEON—1:00 p.m.*****Main Dining Room**

See notice, sent under separate cover, on RESERVATIONS.

*See "Notes" (below).

GENERAL MEETING—2:30 p.m.**Ballroom, Main Floor, North Wing**

1. Address of Welcome. FRANCIS J. TOWNSEND, JR., M.D., President, Worcester County Medical Society.
2. Response. WALTER D. WISE, M.D., President, Medical and Chirurgical Faculty of the State of Maryland.

SCIENTIFIC SESSION

3. Useful Gynecological Procedures in General Practice. RICHARD W. TELINDE, M.D., Professor of Gynecology and Director of the Department of Gynecology, The Johns Hopkins University School of Medicine.
4. The Therapy of Certain Acute Infectious Diseases with a Discussion of the Limitations. THEODORE E. WOODWARD, M.D., Associate Professor of Medicine, University of Maryland School of Medicine.

CRUISE ON "THE QUESTION MARK"—2:30 p.m. to 4:00 p.m.*

Meet on the Sun Porch, Main Floor, Southeast Wing, and the hostesses will make the necessary arrangements for the cruise.

See notice sent under separate cover on reservations.

*See "Notes" (below).

"BREATHHER"—5:00 p.m. to 7:00 p.m.

See copy of "The Visitor," obtainable at all hotels, for general listing of Ocean City Attractions.

THE ATLANTIC OCEAN IS AVAILABLE AT ALL TIMES.**DANCE AND CHAMPAGNE FOUNTAIN—9:00 p.m. to 1:00 a.m.*****Ballroom, Main Floor****Dress—Formal or Informal****Hosts—The Somerset, Wicomico, and Worcester Counties Medical Societies**

See notice sent under separate cover on reservations.

*See "Notes" (below).

PLEASE BE SURE TO MARK YOUR CARD FOR YOURSELF AND NUMBER OF GUESTS SO OUR HOSTS MAY BE NOTIFIED OF THE ACCEPTANCES. SEE RESERVATIONS SENT UNDER SEPARATE COVER.

COMMITTEES

Arrangements Committee: DR. FRANCIS J. TOWNSEND, JR., *Chairman*, DR. I. RIVERS HANSON, and DR. T. B. WHALEY, *Cochairmen*.

Reception Committee: DR. T. B. WHALEY, *Chairman*, Somerset County; DR. HENRY A. BRIELE, Wicomico County; DR. CHARLES T. FISHER, Wicomico County; DR. SETH H. HURDLE, Wicomico County; DR. LOUIS G. LLEWELYN, Worcester County; DR. NORMAN E. SARTORIUS, JR., Worcester County; NATHANIEL R. THOMAS, Worcester County.

Hostess Reception Committee (Woman's Auxiliary): MRS. HENRY A. BRIELE, *Chairman*, Wicomico County; MRS. OSBORNE D. CHRISTENSEN, *Cochairman*, Wicomico County; MRS. DAVID A. GILMORE, Wicomico County; MRS. LOUIS G. LLEWELYN, Worcester County; MRS. WILLIAM B. LONG, Wicomico County; MRS. NORMAN E. SARTORIUS, JR., Worcester County.

Fishing and Cruising Committee: DR. WILLIAM B. LONG, *Chairman*, Wicomico County; DR. NORMAN E. SARTORIUS, JR., Worcester County; DR. ZACK WATERS, Wicomico County; DR. T. B. WHALEY, Somerset County.

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

10:30 a.m. to 12 noon
Wight Room, Atlantic Hotel

Enter through South Entrance on Ground Floor
A cordial invitation is extended to all the ladies to attend this meeting.

*NOTES

HOTEL RESERVATIONS: It is suggested that if you have not made your reservations that you do so immediately by writing to DR. CHARLES W. PURNELL, MANAGING DIRECTOR, ATLANTIC HOTEL, OCEAN CITY, MARYLAND. All reservations for rooms are to be taken care of by the members writing *direct* to the hotel.

The following hotels are the ones cooperating with the Atlantic Hotel and if you are staying at one of these, there will be a refund on each luncheon cover charge of \$2.00:

Atlantic Hotel—Headquarters
Commander Hotel
George Washington Hotel
Roylton Hotel

Rates at the above hotels which include meals, auto parking and ocean bathing facilities are as follows:

\$12.50 per person per day for ocean front, private or connecting bath.
\$11.50 per person per day for ocean or bay view, private or connecting bath.
\$9.50 per person per day for room with running water.

LUNCHEON: Cover charge, including tip, is \$4.00 per person. Checks should be made payable to the Medical and Chirurgical Faculty and should be mailed to 1211 Cathedral Street not later than WEDNESDAY, SEPTEMBER 5, 1951, sooner if possible. Upon receipt of check, luncheon tickets will be mailed promptly. If you are on the American Plan at one of the four cooperating hotels, charge will be two dollars (\$2.00) for luncheon including tip, and you will be refunded two dollars (\$2.00) for each ticket when you register for the meeting.

CRUISE: This feature has been arranged by the Medical and Chirurgical Faculty and tickets will be mailed for those for whom reservation is made. It is necessary to know the number of guests who plan to go on the cruise, so please indicate the number on your reservation card, which has been mailed to you under separate cover.

DANCE AND CHAMPAGNE FOUNTAIN: This is an unusual climax to the Semiannual Meeting and the members are urged to remain for the occasion. So that the host Societies may have the number of guests who will attend, please mark your reservation card which was mailed under separate cover.

PARKING FACILITIES: Large parking lot south of the Atlantic Hotel. Go south from east end of bridge, first turn on Philadelphia Avenue, four blocks to Wicomico Street, turn left one block—lot on northeast corner.

FISHING: Boats available for fishing. See enclosure with this program.

tional expenses incurred should be borne by the Component Society.

With the advent of the Maryland State Medical Journal the 1952 Annual Meeting program was published and sent to all members through this medium. See Vol. 1, No. 3, March 1952, Maryland State Medical Journal, pages 121 to 128. Individual programs will be available for all members who attend the meeting. There will be more exhibits this year than previously, and Dr. Edwin H. Stewart, Jr., has arranged this feature of the Annual Meeting. In an effort to show the appreciation of the Faculty, a small informal cocktail party is being given for the representatives of the firms having exhibits.

I have two recommendations which I wish to make to the House of Delegates, but prior to bringing these before you at the meeting, I would like to make some explanation of the reason for these requests. In May 1951, Dr. Louis Krause and Dr. Lewis P. Gundry, as respective President and Secretary of the Baltimore City Medical Society, were requested not to have their Semiannual Meeting in April, unless done in conjunction with the Annual Meeting of the Medical and Chirurgical Faculty, in order to avoid too many meetings in one month. In February 1952, it was found that the City Medical Society was arranging to meet on April 18, 1952, with a buffet supper following the meeting. Dr. McLanahan, President for 1952, was appealed to again, but nothing was done. Also in May 1951, all hospitals in the City and nursing organizations were requested not to have meetings in April, so that the Annual Meeting of the Medical and Chirurgical Faculty could be concentrated on, and thereby increase attendance at the Annual Meeting.

With the above in mind, it does not seem advisable for Faculty Committees to hold dinner meetings in April. On March 17, 1952, Dr. A. E. Goldstein decided to send out invitations to a subscription dinner on April 7, 1952, for the Building Fund Committee. He was requested to have the dinner in May after the Annual Meeting, but this was not acceptable, thereby, another dinner meeting was posted for the month of April. *Therefore,*

BE IT RESOLVED, that the Committee on Scientific Work and Arrangements recommends to the House of Delegates of the Medical and Chirurgical Faculty that the Committees of the Faculty, the Baltimore City Medical Society, its Sections, the hospitals in the City of Baltimore, and the nursing organizations, be requested not to hold meetings in April which will detract from the attendance at the Annual Meeting of the Medical and Chirurgical Faculty.

BE IT FURTHER RESOLVED, that it is the hope of the Committee on Scientific Work and Arrangements that if the above mentioned organizations, societies, etc., find it impossible to omit meetings in the month of April, that said meetings be held at least three weeks preceding the Annual Meeting of the Medical and Chirurgical Faculty.

Respectfully submitted,
BEVERLEY C. COMPTON, M.D., *Chairman*
WILLIAM L. GARLICK, M.D.
EDWIN H. STEWART, JR., M.D.

PROFESSIONAL CONDUCT COMMITTEE

Mr. President and Members of the House of Delegates:

The entire Professional Conduct Committee met once during the year, on January 16, 1952, and reviewed four complaints. The Executive Committee of the Professional Conduct Committee either met or submitted decisions regarding thirty-one cases, making a total number of thirty-five complaints which were reviewed.

The majority of complaints related to fees and in most instances there was a satisfactory adjustment.

There is now one complaint pending settlement.

A recommendation is being submitted to the House of Delegates, that the By-Laws be amended to read that the Chairman of the Professional Conduct Committee be the senior President serving on the Professional Conduct Committee, instead of the Chairman of the Council.

It is hoped that the House of Delegates will act favorably on this recommendation.

Respectfully submitted,
C. REID EDWARDS, *Chairman*
GEORGE H. YEAGER, M.D., *Secretary*
WALTER D. WISE, M.D., *Past President*
A. AUSTIN PEARRE, M.D., *Past President*
W. HOUSTON TOULSON, M.D., *Past President*
CHARLES W. MAXSON, M.D., *Past President*
WILLIAM T. HAMMOND, M.D., *Past President*
ALAN M. CHESNEY, M.D., *ex-officio*
J. ALBERT CHATARD, M.D., *ex-officio*
EVERETT S. DIGGS, M.D., *ex-officio*

MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

The first issue of the Maryland State Medical Journal was published in January 1952. Originally it had been planned to publish a Journal on a quarterly basis; however, in view of contractual advertising arrangements, it was deemed advisable to publish it on a monthly basis. Because of the fact that most contracts run for the current year, from January 1st to December 31st, it was necessary to publish a January issue.

Publication of a Journal has posed very serious difficulties on the office staff. The present staff has assumed the burden of stenographic work, transcribing, editing and proof reading. In order to establish the Journal as a smoothly running function for the Faculty, it will be necessary to enlarge upon the office staff.

The general reaction to the Journal seems to have been favorable. It is believed that it will serve a worthwhile function, and also add to the prestige of the Medical and Chirurgical Faculty.

Respectfully submitted,
GEORGE H. YEAGER, M.D., *Editor*

MATERNAL AND CHILD WELFARE COMMITTEE

Mr. President and Members of the House of Delegates:

In the death of Dr. J. H. Mason Knox during this calendar year, the medical profession has lost one of its most illustrious members, who contributed much to infant health and welfare during his life, and this Committee has lost one who was responsible more than anyone else for what success it has achieved. In the earlier years he sponsored the Committee and devoted a large part of his time to its work. To him goes all the credit for the establishment and early work of the various prenatal clinics and child health centers in the counties of Maryland. Until just before his death he was one of the most faithful in his attendance at our meetings and was always ready with advice and encouragement. His death has left a vacancy which cannot be filled.

During the year 1951, there was a total of 19 maternal deaths among the residents of the counties of Maryland. Of these, one was adjudged to be non-maternal by the Bureau of Vital Statistics of the State Health Department. On the basis of 19 deaths the mortality rate again fell to the figure of 0.5 per 1,000 live births. The rate for white women was 0.4 per 1,000 while for negroes it was over 4 times as high or 1.8.

Of the 19 deaths, 14 were considered by your Committee to be preventable, the fault lying with the patient in some instances, with the physician in others and both being held culpable in the remainder. There were only 2 deaths which were decided to be non-preventable and in the remaining 3 it was not possible to obtain sufficient information to arrive at any decision as to preventability.

When these 19 deaths are divided as to cause it is found that 8 were associated with hemorrhage, 5 with toxemia, and 6 with miscellaneous causes, only 1 of which was an infection death and this in a patient who had an abortion. There were 4 deaths attributed to pulmonary embolism, and 1 to an unexplained shock following cesarean section.

Two facts seem to stand out from a study of these figures: (1) The comparatively high maternal mortality rate among negroes is an indication of the dire need for better care and more hospital beds for these individuals. It is felt that better care will be an automatic result of hospital beds. In those communities where beds were made available, there has been a decided decrease in mortality. *Your Committee urges that the Faculty do all in its power in this direction.* (2) The fact that more than 40% of the deaths were due to hemorrhage, points a dramatic finger to the great need for more blood banks in strategic locations, to serve a fairly large area. *Again the assistance of the Faculty is sought in the solving of this problem. These blood banks would be of value not only to obstetricians but to all members of the profession.*

Of special interest and satisfaction to this Committee has been the splendid cooperation of the physician in the counties. The reports upon which our studies are based are almost always extremely complete and frank. Practically everyone requests a summary of our findings and when these are critical,

as they must be at times, the criticism is accepted in the spirit of friendly cooperation in which it is offered.

The Committee has developed an immense admiration for the practitioners in the counties and for the excellent results they are obtaining under rather far from ideal circumstances. The mortality rates in the counties compare very favorably with those of Baltimore City or any other city or state.

Pediatric Section of the Committee on Maternal and Child Welfare

During 1951, the Pediatric Section devoted a large part of its time to the study of the causes of premature mortality in the counties of Maryland, because deaths of prematures account for a large percentage of the infant deaths in Maryland. Preliminary figures for 1951 show 673 premature infant deaths in the state (279 among 22,768 live births in Baltimore City and 394 among 32,696 live births in the counties). There was a total of 1,603 infant deaths. Thus, premature deaths are the cause of approximately 41.3% of all infant deaths. The Committee hopes to learn more about the causes of premature mortality by studying case reports. As in the past, survey questionnaires were sent to the doctors reporting deaths of prematurely born infants who survived 48 hours or more. A total of 49 surveys were reviewed. The response of the county physicians to these questionnaires has been excellent. The quality of care given to prematures is very good and improving every year. The Committee congratulates the physicians on their fine work. More autopsies are being performed and this increases our knowledge. There were 14 autopsies done in the 49 cases surveyed. Infection and aspiration of vomitus were the leading causes of mortality among the cases studied.

The Pediatric Section of the Committee continued to serve as the Maryland Committee on Fetus and Newborn of the American Academy of Pediatrics. It is carrying on its work cooperating with the State Department of Health in setting up and maintaining standards of care in hospital nurseries.

During 1951, the Pediatric Section has been interested in the plans and preliminary work being done in preparation for the important Study of Prematures being carried on by the Maternal and Child Health Division of the Johns Hopkins University School of Hygiene and Public Health. This Committee endorses this fine project. There are two main objectives: (1) to learn the effect of different types of hospital care on the neonatal survival of prematures and (2) to learn the physical and mental development of these infants, by follow-up studies years later.

The Committee considers that an important part of its work is educational. More copies of *Suggested Guide for Care of Premature Infants* were distributed. This brochure is in the process of revision and the new form should be ready for distribution in the early part of 1952. In April, the Prince George County Medical Society invited a panel from this section to address one of its meetings. Various aspects of premature infant care were discussed, and a question period followed. This meeting appeared well received and other similar institutes are planned for the future.

The infant mortality rate in 1951 was 28.9 as compared with 28.2 in 1950. The ratio of colored infant deaths to white infants continues high, again emphasizing the need for increased availability of care for colored infants. The Committee repeats its plea for an increase in the quantity and quality of hospital Pediatric beds for colored children.

Respectfully submitted,

LOUIS H. DOUGLASS, M.D., *Chairman*

D. C. WHARTON SMITH, M.D., *Vice-Chairman*

GEORGE W. ANDERSON, M.D.

J. TYLER BAKER, M.D.

JOHN McF. BERGLAND, M.D.

HARRY D. BOWMAN, M.D.

J. EDMUND BRADLEY, M.D.

THOMAS A. CHRISTENSEN, $\frac{1}{2}$ M.D.

GEORGE A. DAVIS, M.D.

DARIUS McC. DIXON, M.D.

NICHOLSON J. EASTMAN, $\frac{1}{2}$ M.D.

H. W. ELIASON, M.D.

A. H. FINKELSTEIN, M.D.

S. BUTLER GRIMES, M.D.

WILSON GRUBB, M.D.

I. R. HANSON, M.D.

VIRGINIA HARRIS, M.D.

PAUL HARPER, M.D.

W. ROYCE HODGES, M.D.

A. W. KITTS, M.D.

WILLIAM K. MANSFIELD, M.D.

J. MORRIS REESE, M.D.

JOHN E. SAVAGE, M.D.

ALEXANDER J. SCHAFER, M.D.

FRANCIS F. SCHWENTKER, M.D.

WILLIAM C. STIFLER, JR., M.D.

BYRON D. WHITE, M.D.

JOHN WHITRIDGE, JR., M.D.

MEMOIR COMMITTEE

Mr. President and Members of the House of Delegates:

Another year has elapsed and it is the unpleasant responsibility of the Memoir Committee to present to the Faculty the names of those members who have died since our last meeting.

Some were young and some were old, but all were engaged in a work blessed by the rendering of service to the ill and the unfortunate.

It is the wish of the Committee that they may be rewarded for the good they have done as honest physicians, whether in general practice or as distinguished in a special field of medicine.

Our sympathy is extended to the families of the deceased on the loss they have suffered.

The following members died during the past year, April 1951, to April 1952:

BALTIMORE CITY

Beck, Harvey G.	October 30, 1951
Blake, Herbert C.	November 20, 1951
Cole, J. Wesley	January 19, 1952
Cotton, Albertus	May 3, 1951
Forsythe, Hugh	April 1950
Hibbitts, John T.	September 24, 1951
Homer, Harry L.	July 27, 1951
Knapp, Hubert C.	December 31, 1951
Knox, J. H. Mason, Jr.	December 31, 1951
Kroll, Louis J.	February 28, 1952
McConachie, Alexander Douglas	September 21, 1951
Onnen, John G.	April 18, 1951
Padget, Paul	October 31, 1951
Pearce, William H.	July 28, 1951
Ries, A. F.	January 3, 1952
Robertson, Fred S.	April 16, 1951
Schaefer, Theodore A.	January 9, 1952
Sudler, Wright S.	November 20, 1951
Wallenstein, Sydney	August 29, 1951
White, Thomas S.	March 6, 1952

ALLEGANY-GARRETT COUNTY

Gracie, W. A.	December 28, 1951
Owens, M. E. B., Sr.	December 6, 1951

ANNE ARUNDEL COUNTY

Hopkins, Walton H.	October 24, 1951
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BALTIMORE COUNTY

Jenifer, Daniel of St. Thomas	April 30, 1951
Sellman, Reginald Oliver	January 25, 1952

CARROLL COUNTY

Stewart, John Joseph	
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DORCHESTER COUNTY

Meredith, Lida O., Cambridge	March 7, 1952
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FREDERICK COUNTY

Roop, E. P.	February 3, 1952
Stone, Otis B.	January 5, 1952
Tyson, Robert S.	March 23, 1951

KENT COUNTY

Burgard, Albert A.	October 17, 1951
Smith, Frank W.	July 16, 1951

MONTGOMERY COUNTY

Horgan, Joseph	November 12, 1951
Howlett, H. H.	January 19, 1952
Stull, H. Tuttle	December 18, 1951

ST. MARY'S COUNTY

Welch Aloysius C.	June 13, 1951
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SOMERSET COUNTY

Lankford, Henry M.....October 7, 1951
 Somers, Charles I.....April 13, 1951

Respectfully yours,
 FRANK J. GERAGHTY, M.D., *Chairman*
 M. McKENDREE BOYER, M.D.
 PHILIP J. BEAN, M.D.
 DAWSON O. GEORGE, M.D.
 W. E. MARTIN, M.D.
 R. M. NOCK, M.D.

EUGENE FAUNTLEROY CORDELL FUND COMMITTEE

Mr. President and Members of the House of Delegates:

Under this Fund there continues to be one beneficiary, who is an elderly lady, and the granddaughter of a physician. She is now a patient at one of our State hospitals.

Several small monthly checks from the Fund were sent to her, but it was recommended by the hospital that certain clothing, a list of which was supplied, be purchased by the Faculty. This was taken care of by two members of the office staff, and it is our understanding that these gifts, which the Eugene Fauntleroy Cordell Fund made possible, have increased the comfort of the patient and made her quite happy.

The balance of this Fund as of January 1, 1952, is \$4,525.10.

Respectfully submitted,
 T. NELSON CAREY, M.D., *Chairman*
 JAMES K. GRAY, M.D.
 WILLIAM L. HOWARD, M.D.
 FRANK F. LUSBY, M.D.
 GEORGE ALLEN MOULTON, JR., M.D.

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

The General Assembly of Maryland was in session for one month only this year, and its considerations were, under the law, limited to fiscal matters and emergency measures in the public interest. This restriction automatically limited bills which would effect or be of interest to the medical profession. Only two bills in this category were introduced, namely; House Bills 63 and 70. These bills, if enacted into law, would have eliminated most of the medical doctors from the Board of Physiotherapy Examiners and would also have permitted physiotherapy practitioners, under certain conditions, to use the title "Doctor." Your Committee opposed these bills, and they were not reported out by the committee of the Legislature to which they were referred. It must be anticipated that these bills will be reintroduced into the 1953 session of the General Assembly.

The Legislative Committee cooperated with the Baltimore City Medical Society in its efforts to encourage the fluoridation of the water supply of Baltimore City. After considera-

tion by the City Council, this bill was passed and fluoridation is to begin on April 1, 1952.

Respectfully submitted,
 KARL F. MECH, M.D., *Chairman*
 FREDERIC V. BEITLER, M.D.
 O. H. BINKLEY, M.D.
 THOMAS A. CHRISTENSEN, M.D.
 J. STANLEY GRABILL, M.D.
 RAYMOND F. HELFRICH, M.D.
 NORBERT C. NITSCH, M.D.
 WILLARD S. PARSONS, M.D.
 DANIEL J. PESSAGNO, M.D.
 J. G. F. SMITH, M.D.
 JAMES E. STONER, JR., M.D.
 GEORGE E. URBAN, M.D.
 I. M. ZIMMERMAN, M.D.

COMMITTEE ON MEDICAL RESEARCH

Mr. President and Members of the House of Delegates:

As Chairman of the Committee on Medical Research, I am compelled to submit a negative report at this time, as there have been no meetings of this Committee.

Respectfully submitted,
 R. WALTER GRAHAM, JR., M.D., *Chairman*
 ALFRED BLALOCK, M.D.
 C. R. EDWARDS, M.D.
 WARFIELD M. FIROOZ, M.D.
 WETHERBEE FORT, M.D.
 ALBERT E. GOLDSTEIN, M.D.
 JOHN H. HORNBAKER, M.D.
 DAVID I. MACHT, M.D.
 L. A. RADEMAKER, M.D.
 W. ALFRED VAN ORMER, M.D.
 THEODORE E. WOODWARD, M.D.
 GEORGE H. YEAGER, M.D.
 ALAN M. CHESNEY, M.D., *ex-officio*
 H. BOYD WYLIE, M.D., *ex-officio*

CANCER COMMITTEE

Mr. President and Members of the House of Delegates:

As in previous years the major portion of the cancer work carried on in the State of Maryland has been under theegis of the Maryland Division of the American Cancer Society. This work continues to function successfully, the major portion of their effort being to educate the public in regard to early diagnosis of cancer, the treatment of indigent patients and furtherance of investigative work.

Within the past year, twenty-eight Detection Centers located in Baltimore City and the counties of Maryland, have continued to be maintained for the examination of the normal individual who wishes to rule out the possibility of cancer. Biopsies from these various centers are transmitted to the laboratories of the Johns Hopkins Medical School and the University of Maryland Medical School; this service is rendered only to medical indigent patients and is not for general

use of routine specimens that might be sent in by physicians. An encouraging note, I feel, is evidenced by the fact that of 2992 women with no symptoms of malignant disease passing through the 28 detection centers located in Baltimore City and the Counties of Maryland, only nine showed carcinoma of the cervix and nine showed suspicious lesions. These figures should encourage the over-anxious individual who is made unstable by cancer phobia.

The Maryland Division of the Cancer Society has available speakers, films and literature which can be supplied to organizations upon request.

This year we are fortunate in having as our leader for the Cancer Campaign, Mr. Robert B. Hobbs, a leader in the financial world. From the present indication it would seem that the cancer drive will be successful, as it has in the previous years.

A telecast was presented by the Gynecological Department of the University of Maryland on *The Diagnosis, Treatment and Cure of Cancer in Women*. This was illustrated with lantern slides, microscopic sections, moulages, diagrams and of especial interest to the viewing audience, five patients who had been treated over a considerable length of time, were present. Television programs have been received quite favorably and we believe that in the future television will play a very important role in the dissemination of knowledge in regard to the treatment of various medical problems.

Respectfully submitted,

J. MASON HUNDLEY, JR., *Chairman*

CHARLES L. BILLINGSLEA, M.D.

C. BERNARD BRACK, M.D.

L. H. BRUMBACK, M.D.

F. A. CAMALIER, M.D.

THOMAS R. CHAMBERS, M.D.

L. CLARENCE COHN, M.D.

BEVERLEY C. COMPTON, M.D.

WILLIAM K. DIEHL, M.D.

EVERETT S. DIGGS, M.D.

NORMAN S. DUDLEY, M.D.

JAMES R. DWYER, M.D.

C. REID EDWARDS, M.D.

WYLIE M. FAW, JR., M.D.

GEORGE G. FINNEY, M.D.

GERALD A. GALVIN, M.D.

SETH H. HURDLE, M.D.

ELLIOTT H. HUTCHINS, M.D.

HOWARD W. JONES, JR., M.D.

EDMUND B. KELLY, M.D.

JAMES T. MARSH, M.D.

JAMES R. MARTIN, M.D.

CLAUDE W. MITCHELL, M.D.

WILLIAM NEILL, JR., M.D.

WILLIAM D. NOBLE, M.D.

JOHN W. PIERSON, M.D.

NORMAN E. SARTORIUS, M.D.

RICHARD W. TELINDE, M.D.

JAMES B. THOMAS, M.D.

ALFRED ULLMAN, M.D.

GRANT E. WARD, M.D.

CHARLES A. WATERS, M.D.

HUGH W. WARD, M.D.

T. B. WHALEY, M.D.

A. L. WILKINSON, M.D.

ELDRIDGE E. WOLFF, M.D.

FRANK D. WORTHINGTON, M.D.

COMMITTEE ON PUBLIC INSTRUCTION

Mr. President and Members of the House of Delegates:

During the year 1951, no meeting of the Committee on Public Instruction was held although Committee activities were in effect and the members have met or communicated informally with each other on various occasions.

The chief work related to public instruction, the Committee's activity field, has been done by the Maryland State Department of Health and the County Health Departments and the Baltimore City Health Department. Detailed records of this work may be found in the Annual Health Department Reports, and in their periodic publications and press releases.

The weekly radio and television programs produced by the City Health Department under joint auspices with the Medical and Chirurgical Faculty of Maryland continued without interruption throughout the year and are considered to have great value in the dissemination of health information. The "Keeping Well" series of radio broadcasts take the form of health dramas and are projected over WFBR as a public service program; the television series, "Your Family Doctor," vary in presentation from week to week depending upon the subject and are telecast over WMAR-TV, the Baltimore Sun-papers organization. Radio has served as a vehicle for the dissemination of health information for twenty years. The Baltimore program which started in 1932 is one of the oldest continuous health radio broadcasts in the country. December 31, saw the 644th radio drama entitled "A Year of Achievement." The part of "Dr. Richard C. Ashley," radio's family doctor, is played by Dr. Nels A. Nelson, Director of the Bureau of Venereal Diseases. The end of the year marked the television program's third anniversary and its 158th presentation. On February 26, Mr. Robert M. Keller replaced Dr. H. Berton McCauley, Director of the Bureau of Dental Care, as television's family doctor, "Dr. John Worthington." Mr. Keller who previously had assisted in the radio dramas and who is a very capable actor, has given the role a very life-like quality that has helped to make the television presentation one of the outstanding public service programs in the city.

During the summer of 1951, a survey was made by the Director of the Bureau of Health Information of the Baltimore City Health Department who has direct supervision of the series. The purpose of the survey was to attempt to evaluate the progress of "Health Via Television" for the purpose of giving better direction to "Your Family Doctor." Form letters containing pertinent questions relating to frequency, format, sponsorship and other details of production were sent to all television stations in the United States. One hundred ten

questionnaires were sent out and sixty-four were returned. A summary of the more pertinent facts regarding health television programs follows: Of those stations replying, seven indicated regular health programs. One station produced a weekly five minute show; one station produced two fifteen minute shows weekly; two stations produced thirty minute shows weekly, and one station produced a thirty minute show every other week.

Oldest of the regular health television programs noted was "Your Family Doctor." Second oldest was "Health Talk," a weekly thirty minute show produced by WGN-TV and the Illinois State Medical Society; this was started in January 1949. "You and Your Health," the two-a-week fifteen minute presentation over WPTZ under the auspices of the Philadelphia Department of Health and the County Medical Society was inaugurated in September 1950, and "It's Your Life," another weekly thirty minute telecast under the auspices of the Michigan Medical Society, had its inception in October 1950. To the question—"Does the station consider television an effective approach to public health education?"—twenty-three answered "highly effective"; fifteen answered "good"; four answered only "fair."

A significant response was had in reply to the question "Do you feel there is room for a network show dealing with health?" To this question thirty-five answered "yes" and one answered "no."

With reference to viewer interest—studio survey records show a gradual increase during the year. Prior to and during 1950, the average number of viewers per week was estimated at no more than 20,000 persons. Early in 1951, this had increased to approximately 40,000 persons. By October 1951, the viewing audience had grown to an estimated 75,000 persons. In November 1951, the survey revealed approximately 85,000 persons attracted to the program. These figures indicate that "Your Family Doctor" exceeds that of many commercially sponsored programs and compares favorably with some outstanding network shows in the entertainment field.

Additional evidence of the public's interest in this program is substantiated by a voluminous correspondence with requests for additional information on the subjects televised.

In view of the apparent success of the television series WMAR-TV has seen fit to submit brochures on this program in two nationwide television competitions; one, the sixteenth annual exhibition of educational television programs sponsored by the Institute for Education by Radio and Television at Ohio State University, and the other which is sponsored by Dupont.

Both radio and television play an integral part in the spread of health information to the citizens of Baltimore and the production of these complementing programs is a result of, and a tribute to, a fine spirit of teamwork that exists between the Health Department and the official and nonofficial health agencies and the physicians and other health workers in the city.

In prior years the detailed and voluminous reports of the State and City Health Departments have been made a part

of the Annual Report of the Committee on Public Instruction but the Committee has felt that such extensive documentation was not needed since the reports are available at the Departments.

Respectfully submitted,
HUNTINGTON WILLIAMS, M.D., *Chairman*
E. COWLES ANDRUS, M.D.
PAGE C. JETT, M.D.
VALCOULON LEM. ELLICOTT, M.D.
WILLIAM D. NOBLE, M.D.
PERRY F. PRATHER, M.D.
JESSE O. PURVIS, M.D.
ROBERT H. RILEY, M.D.
A. F. WHITSITT, M.D.

ARMY MEDICAL LIBRARY COMMITTEE

Mr. President and Members of the House of Delegates:

Our Committee on the Army Medical Library has not met during the last year because of the activities in connection with the Korean war. Every effort, however, is being made to further the progress of the new Library.

With kind regards to the Members of the House of Delegates.

Respectfully submitted,
THOMAS S. CULLEN, M.D., *Chairman*
ANDREW C. GILLIS, M.D.
JOHN T. KING, M.D.
JOHN E. SAVAGE, M.D.
LAWRENCE R. WHARTON, M.D.
SAMUEL WOLMAN, M.D.

COMMITTEE ON INDUSTRIAL HEALTH

Mr. President and Members of the House of Delegates:

The Council on Industrial Health of the American Medical Association sent a lengthy questionnaire covering many aspects of Industrial Health and with the help of the Committee, I answered this.

To those of us who have the opportunity to observe, it is obvious that the physicians of this State have a great lack of knowledge of compensation for occupational diseases, and in fact, are poorly informed about occupational diseases in general. One of the concerns of the Committee has been to correct this, and we have signified our willingness to talk on the subject before any of the County Medical Societies which might request such a lecture.

The 1951 Legislature passed an act making all diseases compensable and a request has been made to insert in the Maryland State Medical Journal a statement calling attention to this and also calling attention to the fact that occupational diseases are reportable.

The Committee holds itself in readiness to advise any of

the physicians of the State on matters of Industrial Health, but has received practically no requests. . .

Respectfully submitted,
 NATHAN B. HERMAN, M.D., *Chairman*
 ROBERT VAN LIEU CAMPBELL, M.D.
 ROBERT F. CHENOWITH, M.D.
 WALTER E. FLEISCHER, M.D.
 WILLIAM L. GARLICK, M.D.
 HUGH C. GILL, M.D.
 W. R. HODGES, JR., M.D.
 JOHN V. HOPKINS, M.D.
 ROBERT H. RILEY, M.D., *ex-officio*
 BENJAMIN H. RUTLEDGE, M.D.
 LEROY W. SAUNDERS, M.D.
 FREDERICK H. VINUP, M.D.
 WILLIAM F. WILLIAMS, M.D.
 HUNTINGTON WILLIAMS, M.D., *ex-officio*

PHYSIOTHERAPY COMMITTEE

Mr. President and Members of the House of Delegates:

I wish to report that the Physiotherapy Committee helped combat an attempt to change our State Physiotherapy Law by a small group of Physiotherapists. A meeting of the Physiotherapy Committee will be held during the Annual State Society Meeting in April to discuss the important problems regarding physiotherapy in Maryland.

Respectfully submitted,
 W. RICHARD FERGUSON, M.D., *Chairman*
 MOSES GELLMAN, M.D.
 HOWARD F. KINNAMON, M.D.
 C. ARTHUR ROSSBERG, M.D.
 ALLEN F. VOSHELL, M.D.
 GRANT E. WARD, M.D.

COMMITTEE TO ADVISE THE STATE INDUSTRIAL ACCIDENT COMMISSION

Mr. President and Members of the House of Delegates:

The Committee to advise the State Industrial Accident Commission has had no occasion to call a meeting during the past year.

This Committee functions only at the request of the State Industrial Accident Commission.

Respectfully submitted,
 CHARLES W. MAXSON, M.D., *Chairman*
 WILLIAM J. COLEMAN, M.D.
 GEORGE O. EATON, M.D.
 WILLIAM R. GERAGHTY, M.D.
 DONALD B. GROVE, M.D.
 HOWARD M. KERN, M.D.
 JAMES W. NELSON, M.D.
 EDWARD P. THOMAS, M.D.

TUBERCULOSIS COMMITTEE

Mr. President and Members of the House of Delegates:

The Tuberculosis Committee has met on two occasions. At the first meeting, Dr. Charlotte Silverman and Dr. Leon

H. Hetherington were kind enough to give us valuable information as regards the progress of care being rendered to patients with tuberculosis in our State.

We are sorry to report that, according to figures submitted by Dr. Hetherington, the waiting list for entrance to the various sanatoria is long. For white males the list is approximately five and one half to six months behind schedule. For white females the period is six to seven weeks behind schedule. For colored females six months behind schedule, but within two months this figure should reach only two months behind schedule when new space will be available at Henryton. For colored males the period is six to seven months behind schedule. It has been pointed out that there is a rather substantial building program going on, and naturally, if the hospital can be appropriately staffed, Dr. Hetherington expects the waiting list to be sharply diminished.

The City of Baltimore, mainly through the efforts of Dr. Silverman along with the Staff of the Baltimore City Hospitals, has initiated an excellent program whereby cases requiring surgery may be admitted to the surgical division and returned home for further care. This allows a fair number of people in Baltimore City to obtain rather quick and necessary treatment.

At present, the State requires admission of patients directly to the sanatorium, before they are sent to one of the General Hospitals in Baltimore for surgery. *It is the feeling of this Committee, that it would be well if the State could find it possible to arrange for appropriate consultation in cases which require surgery and to admit them directly to the General Hospitals for this purpose, so that the patient may return home for continued care until a bed is available in the sanatorium.* This would obviate the necessity of making patients, who are amenable to surgical treatment, wait weeks and months before anything can be done and during which time, the condition may become worse so that they will no longer be candidates for such therapy. It is true, that whenever possible, the State does admit these patients to their hospitals (sanatoria) before their turn. While this may be commendable, it is felt that patients who need medical treatment are prevented from entering in chronological order.

At this point, we emphasize the continued efforts to admit patients to the sanatoria in accordance with the medical indication. *In those instances where patients are required to wait at home for admission, it would be advisable to start medical treatment as soon as possible, and to this end, the City of Baltimore, through Dr. Silverman, has been supplying drugs such as Streptomycin and Paraaminosalicylic Acid. A similar arrangement for the patient in the State would be a definite improvement in the handling of their disease.*

Because of the restrictions as regards the admission of tuberculous individuals by some of the General Hospitals, patients who are able to employ the services of private physicians cannot be admitted promptly. These patients usually require short term periods of hospitalization, varying from one to three weeks, after which they can be adequately treated at home. A more liberal attitude in the admission of known cases of tuberculosis by the General Hospitals would do much to expedite the care of these patients.

The Committee endorses the B.C.G. Vaccination Program

which is being carried out in the City of Baltimore, and recommends that this type of work be extended throughout the State.

Doctors Silverman and Hetherington, who guide the City and State Tuberculosis Programs, have expressed the desire to be cooperative and have furnished this Committee with whatever data has been needed. The Medical Profession and the people of Maryland can count on them to change the appalling situation which has existed for so many years.

I thank the members of this Committee for their cooperation in preparing the above report.

Respectfully submitted,
LAWRENCE M. SERRA, M.D., *Chairman*
OTTO C. BRANTIGAN, M.D.
WILLIAM A. BRIDGES, M.D.
ISADORE LYON, M.D.
JOHN E. MILLER, M.D.
ROBERT H. RILEY, M.D.
SAMUEL WOILMAN, M.D.

COMMITTEE ON MEDICAL SERVICE AND PUBLIC RELATIONS

Mr. President and Members of the House of Delegates:

The Middle Atlantic States Regional Conference will be held in the auditorium of the Philadelphia County Medical Society, 301 South 21st Street, Philadelphia 3, Pennsylvania, on Thursday, May 8, 1952. This will be an all-day session starting at 9:30 a.m.

The first part of the conference will be on the theme *Internal Forces Affecting the Medical Profession*. Representatives of each of the six states composing the conference will report the composite views of their constituents. A digest committee will then formulate the state reports into a condensed form to be presented to the A. M. A. Committee on Medical Service and Public Relations at the American Medical Association Annual Meeting.

The second part of the conference will be devoted to a "contra-theme"—*External Forces Affecting the Medical Profession*. Nationally known speakers will address the assembly on this subject. Members of the state societies interested in these phases of medicine are invited, including particularly members of the State Committees on Public Relations and A. M. A. Representatives.

Dr. Joseph Lawrence, Director of Washington office of A. M. A., and Mr. Thomas Hendricks, Executive Secretary of A. M. A. Council on Medical Service, will speak at the noon luncheon.

Respectfully submitted,
MARIUS P. JOHNSON, M.D., *Chairman*
GEORGE E. URBAN, M.D., *Vice-Chairman*
CHARLES R. AUSTRIAN, M.D.
J. T. B. AMBLER, M.D.
FREDERIC V. BEITLER, M.D.
O. H. BINKLEY, M.D.
J. W. BIRD, M.D.
J. H. BURNS, JR., M.D.
W. D. CAMPBELL, M.D.
H. A. CANTWELL, M.D.
J. ALBERT CHATARD, M.D.

W. H. COULBOURN, M.D.
A. C. DICK, M.D.
E. W. DITTO, JR., M.D.
E. J. EDELEN, M.D.
C. REID EDWARDS, M.D.
D. L. FARBER, M.D.
R. W. FARR, M.D.
JESSE S. FIFER, M.D.
C. T. FISHER, M.D.
C. J. FOLEY, M.D.
W. A. GRIFFITH, M.D.
LLOYD A. HOFFMAN, M.D.
PAGE C. JETT, M.D.
EDGAR A. P. JONES, M.D.
BENDER B. KNEISLEY, M.D.
E. P. KNOTTS, M.D.
H. F. MCPHERSON, M.D.
J. T. MARSH, M.D.
C. W. MITCHELL, M.D.
W. B. MOYERS, M.D.
W. D. NOBLE, M.D.
G. B. QUEEN, M.D.
ROBERT H. RILEY, M.D.
J. G. SASSCER, M.D.
ARTHUR M. SHIPLEY, M.D.
F. E. SHIPLEY, M.D.
M. H. SPRECHER, M.D.
FRANKLIN SUSAN, M.D.
A. C. WELCH, M.D.
R. S. G. WELCH, M.D.
A. F. WHITSITT, M.D.
HUNTINGTON WILLIAMS, M.D.
W. F. WILLIAMS, M.D.
E. H. WILSON, M.D.
J. R. WANNER, M.D.
L. K. WOODWARD, M.D.

MENTAL HYGIENE COMMITTEE

Mr. President and Members of the House of Delegates:

The Mental Hygiene Committee has no positive report for the past year.

Respectfully submitted,
HOSEA W. MCADOO, M.D., *Chairman*
DEXTER M. BULLARD, M.D.
ROBERT E. GARDNER, M.D.
ALFRED T. GUNDY, M.D.
KENNETH B. JONES, M.D.
WENDELL S. MUNCIE, M.D.
H. WHITMAN NEWELL, M.D.
ESTHER L. RICHARDS, M.D.
IRVING J. SPEAR, M.D.

COMMITTEE ON RURAL MEDICINE

Mr. President and Members of the House of Delegates:

There have been no called meetings of the Committee on Rural Medicine. Information obtained by the Chairman

shows considerable easing of the doctor shortage in rural communities.

The Chairman, however, spoke before the Junior Class at the University of Maryland on rural practice, and at that meeting attempted to determine whether the Juniors wish to spend their vacation in a rural hospital or possibly with a carefully selected rural doctor as a preceptor.

To date, we have had a very enthusiastic response regarding the intent of these young men to come into rural practice, and four men have volunteered for preceptorship this coming vacation period.

We would like to have the Faculty advise whether or not they are in favor of this program and what legal status this relationship would involve.

Respectfully submitted,
 PAGE C. JETT, M.D., *Chairman*
 MORRIS FRANKLIN BIRELY, M.D.
 ARTHUR TALBOT BRICE, M.D.
 THOMAS A. CHRISTENSEN, M.D.
 P. E. COX, M.D.
 LOUIS H. DOUGLASS, M.D.
 JOHN FAWSETT, M.D.
 J. STANLEY GRABILL, M.D.
 JOHN H. GRIFFIN, M.D.
 JAMES W. MEADE, M.D.
 HAROLD B. PLUMMER, M.D.
 ERNEST F. POOLE, M.D.
 ROBERT H. RILEY, M.D.
 DEAN W. ROBERTS, M.D.
 WALTER H. SHEALY, M.D.
 H. J. SLUSHER, M.D.
 MILFORD H. SPRECHER, M.D.

COMMITTEE ON THE CONSTITUTION AND BY-LAWS

Mr. President and Members of the House of Delegates:

This Committee held several meetings during the year and in compliance with request from the Council, made studies and recommendations to the Council in reference to suggested changes in the Constitution and By-Laws.

In some instances, the Committee recommended that the Constitution and By-Laws not be changed, and in other cases it felt that there should be amendments to the By-Laws.

On March 26th, Dr. George H. Yeager, the Secretary of the Faculty, sent to the Presidents and Secretaries of the Component Medical Societies and the members of the House of Delegates of the Medical and Chirurgical Faculty, the amendments both to the Constitution and to the By-Laws which are to be acted upon at the meeting on Tuesday, April 29th and Wednesday, April 30th.

The following are the recommended amendments:*

The House of Delegates approved this amendment at its meeting in April 1951, and final action will be taken on Tuesday, April 29, 1952, in conformity with the Constitution.

Article VIII. Sessions and Meetings.

Section 1. The Annual Meeting of the Faculty shall be held in the City of Baltimore IN THE SPRING, THE TIME TO BE DESIGNATED EACH YEAR BY THE PRESIDENT OF THE FACULTY AND THE COUNCIL AT, OR PRECEDING, THE JUNE MEETING OF THE COUNCIL, and the Semianual meetings may be called at such time and place as the Council may designate.

AMENDMENTS TO BY-LAWS

To be presented to the House of Delegates on Tuesday, April 29, 1952, final action to be taken by the House of Delegates on Wednesday, April 30, 1952.

Chapter I. Membership.

Section 3. Associate Members. Doctors of Medicine or those holding academic degrees of equal rank, who are not engaged in the private practice of medicine, shall be eligible for associate membership.

ONLY THOSE ASSOCIATE MEMBERS WHO PAY THE FULL RATE OF \$15.00 PER YEAR SHALL RECEIVE THE JOURNAL, WITHOUT ADDITIONAL COST.

(This is a new paragraph, and has never appeared in the Constitution before.)

(The remainder of Section 3 is unchanged.)

Chapter II. Dues.

Section 2. The annual dues for associate members shall be \$15.00 per year, and shall be payable January 31, in advance, with the following exception: . . . (Remainder of section unchanged).

(The amendment is to change the dues of Associate members from \$5.00 to \$15.00.)

Chapter VIII. Standing Committees.

Section 1. (Paragraph II) The standing committees, WHICH ARE to be named by the President, ARE: Nominating Committee, RESOLUTIONS COMMITTEE.

(Paragraph III) Standing Committees, organized as hereinafter provided, are: House Committee, Finance Committee, PROFESSIONAL CONDUCT COMMITTEE AND RESOLUTIONS COMMITTEE.

Section 8. PROFESSIONAL CONDUCT COMMITTEE.

This Committee shall consist of the five immediate Past Presidents of the Medical and Chirurgical Faculty with the SENIOR PAST PRESIDENT as Chairman of the Committee. The function of this Committee will be to hear legitimate grievances against members of the Society, examine the facts of the grievances and make recommendations as to their disposition to the Council of the Faculty.

Section 9. RESOLUTIONS COMMITTEE. THE RESOLUTIONS COMMITTEE SHALL CONSIST OF FIVE MEMBERS TO BE APPOINTED ANNUALLY BY THE PRESIDENT OF THE MEDICAL AND CHIRURGICAL FACULTY, WHO SHALL

ALSO DESIGNATE THE CHAIRMAN OF THE RESOLUTIONS COMMITTEE. THIS COMMITTEE SHALL BE CHOSEN FROM THE HOUSE OF DELEGATES, AND SHALL BE APPOINTED AT LEAST 30 DAYS BEFORE THE ANNUAL MEETING OF THE HOUSE OF DELEGATES.

ANY NEW BUSINESS INVOLVING A QUESTION OF POLICY, WHICH HAS NOT PREVIOUSLY BEEN CONSIDERED BY THE COUNCIL OR THE HOUSE OF DELEGATES, SHALL BE REFERRED TO THE RESOLUTIONS COMMITTEE FOR CONSIDERATION, BEFORE BEING ACTED ON BY THE HOUSE OF DELEGATES. THE RESOLUTIONS COMMITTEE SHALL REPORT TO THE HOUSE OF DELEGATES AT THE TIME INDICATED BY THE CHAIRMAN OF THE HOUSE OF DELEGATES.

Respectfully submitted,
LAWRENCE R. WHARTON, M.D., *Chairman*
CLEWELL HOWELL, M.D.
JOHN T. KING, M.D.

* Amendments are in capitals.

COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE*

Brigadier General Robert P. Williams, Retired,
Chief, Medical Services, Civil Defense

Dr. Robert H. Riley, Chairman of the Advisory Council, Medical Services, Civil Defense of Maryland, will be out of the country at the time of the meeting of the House of Delegates, Medical and Chirurgical Faculty of the State of Maryland. He has requested General Robert P. Williams, Chief of Medical Services, Civil Defense of Maryland, to prepare the annual report summarizing the activities of the Medical Services program of Civil Defense.

No meetings of the Advisory Council were held during the year. Previous action by this committee was adequate to keep all of the committees listed in Dr. Riley's report of 1951 satisfactorily employed during the year. The Chief, Medical Services, Civil Defense, plans to request a meeting of the Advisory Council in the early fall, at which time he will summarize achievements of the Medical Services and request the support and advice of the Council.

There was one meeting of the Steering Committee of the Advisory Council called 3 January, 1952, at the request of the Chief of the Medical Services. The Steering Committee inquired into coordination of Red Cross Disaster Service with

Civil Defense. This meeting was followed by a conference between Dr. Ralph G. Hills, Chairman of the Medical and Nursing Committee for Baltimore City, American Red Cross, and the Chief of the Medical Services, C. D., in which agreement was reached as to the spheres of activity of Red Cross and Civil Defense in various types of disaster, with the assurance that Red Cross individuals and units would have similar assignments in the Civil Defense organization so that, having gone into action under the Red Cross, they could be absorbed into the larger Civil Defense organization without unnecessary reassignments or movements of individuals and units.

During the first 10 months of the year the various committees of the Medical Services of Civil Defense were engaged in preparation and publication of medical bulletins outlining the organization and responsibilities of the various portions of the medical organization: (Appendix No. 1.)

MEDICAL BULLETIN NO.	DATE ISSUED	SUBJECT
8	May 4, 1951	Nursing
9	May 23, 1951	Initial Stages—Medical Personnel
10	June 8, 1951	Auxiliary Workers
11	July 2, 1951	Medical Personnel Ques- tionnaires
12	July 5, 1951 (Revised 11/19/51)	Casualty Flow Chart
13	July 20, 1951	Medical Supplies and Drugs
14	August 15, 1951	Auxiliary Workers
15	August 31, 1951	Emergency Hospitals— Table of Organization
16	August 20, 1951	Nursing Training Pro- gram in Civil Defense
17	August 20, 1951	Nursing
18	August 20, 1951	Publicity for Nursing Census
19	August 28, 1951	Emergency Laboratory Services
20	October 15, 1951	Biological Warfare
	November 12, 1951	Committees for Recruit- ment and Training of Auxiliary Workers

Organization of the Medical Services remained unchanged. Dr. Edward Davens' Normal Home and Office Services Committee was given the new title of Essential Community Services Committee. This change was made as the new term was believed more descriptive of the activities of this large and important committee.

Memorandum No. 1, dated 22 October, 1951, is of special interest. (Appendix No. 2.) This is on the subject of First Aid and Casualty Evacuation and was published as Section XXIII of the Maryland Civil Defense Plan. This is the first portion of the State Plan dealing solely with medical activities.

* Robert H. Riley, Chairman, and Director of Health Service Division. *Steering Committee of the Advisory Council to the Director of the Health Service Division for Civil Defense:* J. Albert Chatard, M.D., Alan M. Chesney, M.D., C. Reid Edwards, M.D., Charles W. Maxson, M.D., Walter D. Wise, M.D., George H. Yeager, M.D., Mr. George Buck and Mr. Walter N. Kirkman.

From March to 30 November, 1951, Mr. Herbert G. Fritz was Acting Deputy Director of the Health Service Division. It was during this period that the issue of most of the broad plans and policies was made.

On 1 December, 1951, Brigadier General Robert P. Williams was appointed Chief, Medical Services, Civil Defense of Maryland, and assumed duty on 3 December. General Williams was the first full-time member of the Medical Service of Civil Defense at the State level. During the period 6–12 January, 1952, he attended the Federal Civil Defense Staff College at Olney. During December and January he met the members of the State committees, learning the accomplishments of these committees and giving them directives for further action. Commencing in January, he has been engaged in contacting Civil Defense Directors and Medical Directors of the various counties in the county seats. First attention was given to the cities and counties comprising the metropolitan areas of Baltimore and Washington, D. C., with particular attention to the mutual aid which these elements could expect.

A brief numerical report was requested of the counties for the calendar year 1951. This was published as a memorandum dated 25 February, 1952 (Appendix No. 3.) From this report it will be seen that very little had been accomplished in organization of first aid teams and casualty clearing stations, and that the bulk of professional individuals who had volunteered for Civil Defense duty remained unassigned. It was decided that these volunteers should be assigned as rapidly as possible and that emphasis should be placed upon organizing and training casualty clearing stations. (See below.)

Conferences with the various committees of Civil Defense were continued. General Williams attended or conducted conferences as follows:

8 during December, 1951
15 in January
21 in February
and 16 in March to the date of this report.

Casualty Clearing Stations

Early in his contacts with the local Civil Defense authorities, it was learned that implementation of State and Federal plans, implementation which necessarily must be effected at the local level, had been delayed due to innumerable details, responsibilities and decisions resting on local Civil Defense Directors and their Medical Directors. It was decided that a start must be made somewhere and the casualty clearing station, the place to which all casualties will be brought and where they will first be given the professional care of doctors and nurses, seemed the logical place to start. Early in January, emphasis was placed upon the organization and training of casualty clearing stations in every city and county of the State.

In focusing attention on this echelon of the medical service of Civil Defense, it was not intended to detract from the importance of all of the other Civil Defense activities. However, the fact that there is no counterpart of this station in normal peacetime, and its immediate service to casualties, led to this choice. It was suggested to county Medical Direc-

tors that maximum decentralization be effected in the recruiting and training of these units. It was hoped that civic minded individuals, small groups or communities, once started and with enthusiasm aroused, would complete their organization and secure training first of individuals and then of the entire station. (See *Casualty Clearing Stations, Civil Defense*, by Brigadier General Robert P. Williams, in the February, 1952, issue of the MARYLAND STATE MEDICAL JOURNAL.)

At the end of 1951 there were 59 casualty clearing stations either wholly or partially manned in the State. This emphasis upon the C.C.S. has resulted in an increase of more than 100 percent in the number of these stations since the first of the year. As the casualty clearing station develops it should recruit and train the first aid stations which will bring casualties into the clearing station. With the completion of this recruitment, a very large portion of the volunteers trained solely for Civil Defense purposes will be organized into units.

Upon recommendation of the Chief of Medical Services, Civil Defense, equipment and supplies for 150 casualty clearing stations and their satellite first aid stations were purchased by matching Federal and State funds. (For details, see below.) The first of this equipment is now arriving. It will be repackaged and distributed to the individual casualty clearing stations, thus assuring dispersal of supplies and the readiness of these stations to function without delay. It is expected that the State will have the full 150 casualty clearing stations by midsummer and will continue organizing and training until a total of 200 are assured for the State. Casualty clearing station personnel, because of the nature of their work, can be expected to function for only about 12 hours when they should be relieved by a new completely organized team; hence, the equipment for 150 stations, but with organization of the personnel for 200 teams, is considered an appropriate ratio.

American Red Cross

Several conferences were held with the Red Cross on the subject of A. R. C. training activities in connection with Civil Defense. The Red Cross has accepted the responsibility of training, particularly in first aid, nurses aides and home nursing, the volunteers required by Civil Defense. Early this year Red Cross undertook to re-train all of its first aiders in the technique of the Holger-Nielsen method of artificial respiration, the so-called back pressure-arm lift method, which has proved far superior to the Schaefer method, particularly in handling nerve gas cases.

Nursing Institute

A Civil Defense Nursing Institute was held in Baltimore 14–15 February. It was attended by more than 150 graduate nurses representing all counties. The agenda were prepared with the objective of preparing those in attendance to carry information back to their counties and to secure the widest possible dissemination.

Public Relations

Several articles and interviews were released. Particular attention is called to *Maryland's Civil Defense Medical Ser-*

ices, by Dr. Robert H. Riley, Director, and Mr. Herbert G. Fritz, Acting Deputy Director, in the January, 1952, issue of the MARYLAND STATE MEDICAL JOURNAL, and *Casualty Clearing Stations, Civil Defense*, by Brigadier General Robert P. Williams, Chief, Medical Services, Civil Defense, in the February, 1952, issue of the MARYLAND STATE MEDICAL JOURNAL.

From time to time the attention of Civil Defense officials will be called to articles appearing in the journals which seem particularly appropriate to them. As an example, *Civil Defense from a Health Officer's Viewpoint*, by Dr. Harold D. Chope, published in the February, 1952, issue of the American Journal of Public Health, was reproduced (Appendix No. 4) and distributed to all Civil Defense Medical Directors and county Directors of Civil Defense and members of State committees.

The Chief, Medical Services, Civil Defense, appeared several times on local radio and television shows.

Funds

Federal Civil Defense appropriations during the present fiscal year were disappointingly low. However, Maryland was able to match funds as far as Federal sums would go. After repeated meetings it was agreed to obligate \$628,000, half Federal and half from State and local funds. Actual purchases were all made by the Federal Civil Defense to allow utmost bargaining power. This amount will purchase complete equipment for 150 casualty clearing stations plus certain items which will be used in treatment of casualties, both in the casualty clearing stations and Civil Defense hospitals. This latter category comprises blood plasma and antibiotics. Arrangements have been made so that antibiotics will be rotated through the hospitals, participating hospitals being obligated to main inventories adequate to replace all drugs loaned from Civil Defense sources. One exception to this plan was made in the case of penicillin, which will be rotated through the State and local Health Department V. D. clinics.

Plans

Program for medical Civil Defense activities for the coming year:

1. Prompt assignment of all professional volunteers to appropriate Civil Defense units.
2. Emphasis to continue on organization and training of casualty clearing stations until approximately 200 have been well started. These units will then be required to continue their own training.
3. The Chief of Medical Services to convene meetings of Medical Directors in each of the metropolitan areas, to coordinate mutual aid.
4. After casualty clearing stations have received their equipment, to hold a series of demonstrations and rehearsals designed to familiarize them with their duties and to acquaint communities and other Civil Defense services with the capabilities and limitations of the stations.
5. To secure a semi-annual report of accomplishments from the counties as of July 1, 1952. This report will show not only achievements but will also indicate bottlenecks and areas of

apathy. It is planned to ask for a meeting of the Advisory Council for consideration of this semi-annual report and the construction of a program covering the succeeding months. It is believed that by midsummer emphasis may be turned from the casualty clearing station to completion of assignment of staffs, both professional and non-professional, to existing and emergency hospitals.

6. Sometime early in 1953 emphasis should be placed on Essential Community Services, with the development of community clinics and the training of large groups of home nurses. During that year, effort will be made to increase the number of professional volunteers to include all members of local and State medical societies.

Appendices Nos. 1 to 4, inclusive, are available from the files of the Maryland State Department of Health.

BLOOD BANK ADVISORY COMMITTEE

Mr. President and Members of the House of Delegates:

The Blood Bank Advisory Committee has conferred on a number of occasions with the Blood Program Committee of the Baltimore chapter of the American Red Cross. In August, 1951 a regional defense center was established which has been collecting blood under a contract with the Department of Defense. The Committee has assisted in the selection of a medical director and other professional personnel. From time to time as problems arose, the advice of the Advisory Committee was sought. At the moment the center is apparently operating fairly smoothly.

Respectfully submitted,
MILTON S. SACKS, M.D., *Chairman*
WALTER A. BAETJER, M.D.
WALTER C. MERKEL, M.D.
H. RAYMOND PETERS, M.D.
MARK M. RAVITCH, M.D.
MERRELL L. STOUT, M.D.
JOHN WHITRIDGE, JR., M.D.

MEDICAL CARE CAMPAIGN COMMITTEE

Mr. President and Members of the House of Delegates:

The Medical Care Campaign Committee has been relatively inactive during the past year. It has continued to coordinate American Medical Association educational literature, and it has made contact with our Senators and Representatives in Washington with reference to various types of legislation.

Respectfully submitted,
GEORGE H. YEAGER, M.D., *Chairman*
BENJAMIN M. BAKER, JR., M.D.
JOHN M. T. FINNEY, JR., M.D.
JAMES T. MARSH, M.D.
GEORGE MCLEAN, M.D.

SPEAKERS BUREAU OF THE MEDICAL CARE CAMPAIGN COMMITTEE

Mr. President and Members of the House of Delegates:

There is little to report for the Speakers Bureau of the Medical Care Campaign Committee, except that one talk was given by the writer before the Young People's Group of the Brown Memorial Church in November of 1951. Members of the Speakers Bureau have been used by Mrs. Naomi Duff Smith, who has been doing the Public Relations work for the Baltimore City Medical Society, but no direct contact has been made with the Speakers Bureau as such.

Respectfully submitted,
 WHITMER B. FIROR, M.D., *Chairman*
 CONRAD ACTON, M.D.
 LEO BRADY, M.D.
 ARCHIE ROBERT COHEN, M.D.
 NEWLAND E. DAY, M.D.
 GEORGE G. FINNEY, M.D.
 JOHN M. T. FINNEY, JR., M.D.
 WARFIELD M. FIROR, M.D.
 H. HANFORD HOPKINS, M.D.
 J. MASON HUNDLEY, JR., M.D.
 PAGE C. JETT, M.D.
 MARIUS P. JOHNSON, M.D.
 HARRY F. KLINEFELTER, JR., M.D.
 AMOS R. KOONTZ, M.D.
 ELLA LONN, A.M., Ph.D.
 ERWIN E. MAYER, M.D.
 GEORGE MCLEAN, M.D.
 EMIL NOVAK, M.D.
 MILDRED OTENASEK, M.D.
 MAURICE C. PINCOFFS, M.D.
 J. MORRIS REESE, M.D.
 SULLINS G. SULLIVAN, M.D.
 CHARLES H. WILLIAMS, M.D.

SESQUICENTENNIAL COMMITTEE (NEW BUILDING)

Mr. President and Members of the House of Delegates:

As of this date, there is no additional report from the Sesquicentennial Committee. However, Dr. Goldstein has called a dinner meeting of the Building Fund Committee, on April 7th, at which time he will outline plans for the campaign to secure funds.

Respectfully submitted,
 C. REID EDWARDS, M.D., *General Chairman*

A. FINANCE COMMITTEE (NEW BUILDING)

Mr. President and Members of the House of Delegates:

After the fall meeting in Ocean City in 1951, the Committee of the Building Fund convened on several occasions and sug-

gested the advisability of assessing each member of the State Society an amount to be paid over a period of three or four years to be applied to the Building Fund. This was presented to the Council for adoption, but was rejected by the Council on the strength that there would be a loss of a percentage of members if adopted. Nevertheless, the campaign continued and is still active in attempting to raise funds but has lost a great deal of momentum because of the lack of interest on the part of a great proportion of the members. The greatest lack of interest is with the county members.

To date there have been subscriptions made by only twenty-four per cent of the total membership of the State Society. Considering the City members separately from the county members we have received subscriptions from about forty per cent against five per cent of the county members. In converting this into dollars and cents, we have total subscriptions of approximately \$78,000. Of this amount approximately ninety-five per cent of the amount or \$72,000 has come from the city members and about eight per cent or \$6,000 from the county members. This, of course, is not a very happy situation as far as interest is concerned. There is no question but that more subscriptions will be obtained.

Other interesting figures are the following: Only forty-five per cent or 675 city members have been solicited of which 580 have pledged some amount. The other fifty-five per cent or approximately 750 city members have as yet never been approached. In the counties every member has been solicited either by letter, card or in person but to date the returns have not been encouraging. We feel quite certain that the largest percentage of city members who have not been approached will subscribe. The reason they have not been contacted is because we are dependent on very busy doctors who are on the committee and who have done an unusually good piece of work. They can only see so many because of their other activities but will eventually cover the entire membership. We hope to add other members to the Committee so that we might enlarge our Committee and at the same time relieve some of those who have been active. We can always accept volunteers. Just what can be done to arouse the interest of the county members is open for suggestions at all times.

We are particularly anxious to reach an amount of subscriptions to the extent of \$150,000. When we reach this amount there have been many promises made by industry and business concerns that they will be willing to contribute but not before fifty per cent of the total amount required is subscribed by the medical men. One can hardly expect a more sane statement from them.

The Committee would appreciate it if every one would consider this and if they have not signed up as yet, please do so as soon as possible. Appoint yourself as a Committee of one and obtain at least one subscription from your fellow physician. This is your library and building and unless we stand together we are doomed for failure.

At this time I desire publicly to express my deep apprecia-

tion for the untiring efforts made by the entire committee in doing as much as they have.

Respectfully submitted,
A. E. GOLDSTEIN, M.D., *Chairman*
JOHN W. PARSONS, M.D., *Treasurer*
Subcommittee

WARDE B. ALLAN, M.D.
JAMES G. ARNOLD, JR., M.D.
WALTER A. BAETJER, M.D.
ALAN BERNSTEIN, M.D.
C. BERNARD BRACK, M.D.
LEO BRADY, M.D.
OTTO C. BRANTIGAN, M.D.
HENRY A. BRIELE, M.D.
EDWIN N. BROYLES, M.D.
FERDINAND E. CHATARD, IV, M.D.
BEVERLEY C. COMPTON, M.D.
NEWLAND E. DAY, M.D.
LOUIS C. DOBIHAL, M.D.
LOUIS H. DOUGLASS, M.D.
MONTE EDWARDS, M.D.
J. M. T. FINNEY, JR., M.D.
WETHERBEE FORT, M.D.
FRANK J. GERAGHTY, M.D.
THOMAS K. GALVIN, M.D.
MARK E. GANN, M.D.
ROBERT W. GARIS, M.D.
LEWIS P. GUNDRY, M.D.
ALAN F. GUTTMACHER, M.D.
LOUIS P. HAMBURGER, SR., M.D.
H. HANFORD HOPKINS, M.D.
HARRY C. HULL, M.D.
J. MASON HUNDLEY, JR., M.D.
PAGE C. JETT, M.D.
HUGH J. JEWETT, M.D.
MARIUS P. JOHNSON, M.D.
E. PAUL KNOTTS, M.D.
AMOS R. KOONTZ, M.D.
EDWARD F. LEWISON, M.D.
E. T. LISANSKY, M.D.
HELEN I. MAGINNIS, M.D.
W. KENNETH MANSFIELD, M.D.
ERWIN E. MAYER, M.D.
KARL F. MECH, M.D.
WALDO B. MOYERS, M.D.
W. RAYMOND MCKENZIE, M.D.
SAMUEL McLANAHAN, M.D.
EMIL NOVAK, M.D.
FRANK J. OTENASEK, M.D.
DANIEL J. PESSAGNO, M.D.
ESTHER L. RICHARDS, M.D.
HARRY M. ROBINSON, JR., M.D.
FRED B. SMITH, M.D.
HOWARD C. SMITH, M.D.
RICHARD W. TELINDE, M.D.
EDWARD P. THOMAS, M.D.
W. HOUSTON TOULSON, M.D.
I. RIDGEWAY TRIMBLE, M.D.

HENRY F. ULLRICH, M.D.
LAWRENCE R. WHARTON, M.D.
WALTER D. WISE, M.D.
AUSTIN H. WOOD, M.D.
ALAN C. WOODS, M.D.
ISRAEL S. ZINBERG, M.D.

B. BUILDING PLANS COMMITTEE (NEW BUILDING)

Mr. President and Members of the House of Delegates:

The Chairman of the Building Plans Committee submits a negative report at this time, as there has been no meeting of this Committee, nor any plans brought before it, other than the present indefinite status of the new building.

Respectfully submitted,
R. WALTER GRAHAM, JR., M.D., *Chairman*
HARRY CLAY HULL, M.D.
I. RIDGEWAY TRIMBLE, M.D.

POSTGRADUATE EDUCATIONAL COMMITTEE

Mr. President and Members of the House of Delegates:

This Committee has been re-organized during the current year so as to include representatives of the main geographical divisions of Maryland, and representatives of the general practitioners, and of those who are not connected with educational institutions, as well as of those who are directly concerned with medical education and specialist training. Data and opinions are being collected concerning the availability and value of the various means of continuing medical education.

Discussion has been initiated on the nature of the role to be played in this area by the Medical and Chirurgical Faculty of Maryland. At a later date, recommendations will be formulated and submitted to the President.

Respectfully submitted,
EDWARD S. STAFFORD, M.D., *Chairman*
O. H. BINKLEY, M.D.
J. EDMUND BRADLEY, M.D.
JOHN McC. CULLER, M.D.
ROBERT E. FARBER, M.D.
GEORGE J. KREIS, JR., M.D.
JAMES T. MARSH, M.D.
CLAUDE W. MITCHELL, M.D.
ROBERT B. SASSCER, M.D.
EDWARD J. SIMON, M.D.
ELIZABETH P. TREVETT, M.D.
LOUIS S. WELTY, M.D.
WALTER L. WINKENWERDER, M.D.

DIABETIC DETECTION COMMITTEE

Mr. President and Members of the House of Delegates:

The Committee cooperated with the American Diabetes Association in the conduction of its fourth annual drive for

the detection of diabetes during the week of November 11th through the 17th. A folder outlining briefly the part the individual physician can play in the detection of diabetes, entitled *Finding the Diabetic in Your Community*, was sent to every physician in the State. Detection Centers were set up in one County and six Baltimore hospitals. The laboratory data of each individual found to have diabetes was forwarded to the physician of his choice.

By means of posters, newspaper articles, television and radio programs, an effort was made to get the individual to consult his local physician for diabetic screening. The number examined by the local physicians as the result of this publicity, of course, is not known. However, approximately 1500 people were screened at the Detection Centers and 72 unknown cases of diabetes were found.

Respectfully submitted,
 J. SHELDON EASTLAND, M.D., *Chairman*
 E. IRVING BAUMGARTNER, M.D.
 T. NELSON CAREY, M.D.
 JAMES D. CARR, M.D.
 J. WILFRID DAVIS, M.D.
 PERRY FUTTERMAN, M.D.
 FRANK J. GERAGHTY, M.D.
 DAVID J. GILMORE, M.D.
 LEWIS P. GUNDRY, M.D.
 J. ROY GUYTHER, M.D.
 THURSTON HARRISON, M.D.
 JOHN H. HORNBAKER, M.D.
 BENJAMIN F. JONES, M.D.
 RICHARD B. NORMENT, III, M.D.
 CHARLES F. O'DONNELL, M.D.
 HAROLD PLUMMER, M.D.
 J. EMMETT QUEEN, M.D.
 DEAN W. ROBERTS, M.D.
 BENJAMIN H. RUTLEDGE, M.D.
 GEORGE G. SCHLESINGER, M.D.
 FRANK M. SHIPLEY, M.D.
 A. A. SILVER, M.D.
 BENEDICT SKITARELIC, M.D.
 LESTER A. WALL, JR., M.D.

SCIENTIFIC SPEAKERS BUREAU

Mr. President and Members of the House of Delegates:

The inauguration of the Scientific Speakers Bureau was brought to the attention of the House of Delegates at its meeting in April 1951. A booklet, containing a list of available speakers and topics, was distributed to the Component Medical Societies.

Eighteen speaking engagements have been filled, and in only one instance was it impossible to supply a speaker to a Component Medical Society because of lack of time. All Component Medical Societies have been requested to notify the Scientific Speakers Bureau at least four weeks in advance of the date of the meeting for which they desire a speaker. It has been found that it is not fair to ask one of the members of the Medical and Chirurgical Faculty, serving on the Scien-

tific Speakers Bureau, to fill an engagement on a week or ten days notice.

In most every instance, when a request came through for a speaker, the member approached has gladly accepted the speaking engagement. We all know that this, in many instances, involved change of schedule and in some cases may work a hardship.

At the time of the organization of the Scientific Speakers Bureau, those who volunteered in this capacity, were told that they would only be asked to accept one engagement during the year. We have adhered to this procedure, and therefore, in some instances it has not been possible to supply some Societies with their first choice, although in every instance a speaker has been supplied.

I wish to express my appreciation through this medium to those speakers who accepted, so graciously, these speaking engagements.

Respectfully submitted,
 BEVERLEY C. COMPTON, M.D., *Chairman*
 ALAN M. CHESNEY, M.D. (*ex-officio*)
 WILLIAM K. DIEHL, M.D.
 WILLIAM E. GROSE, M.D.
 H. BOYD WYLIE, M.D.

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Mr. President and Members of the House of Delegates:

Pursuant to the action of the Council and the House of Delegates at the spring meeting, the request of those bodies has been transmitted to the Woman's Auxiliary that they give consideration to the revision of the Constitution of the Woman's Auxiliary to provide that they shall render active support to pending legislation or oppose the same, according to the stated policies of the Council and the Medical and Chirurgical Faculty.

The Woman's Auxiliary has shown an active interest at the state and at the local level in the problem of narcotic addiction. Following the joint meeting of the lawyers and the doctors on this subject, which was held at the Headquarters of the Faculty, the officers of the Woman's Auxiliary and members of the Advisory Committee met with Mr. William Jett, Chairman of the Citizens Committee in this field, for a discussion of how the Woman's Auxiliary could most effectively participate in combating this problem. Pursuant to this, the Woman's Auxiliary has, I understand, proceeded with a plan which was partially formulated in advance of this meeting to create a standing committee in their body to deal with the narcotic problem.

Respectfully submitted,
 E. COWLES ANDRUS, M.D., *Chairman*
 WHITMER B. FIROR, M.D.
 THURSTON HARRISON, M.D.
 AMOS R. KOONTZ, M.D.
 WALDO B. MOYERS, M.D.

COMMITTEE TO CONSIDER THE RELATIONSHIP BETWEEN HOSPITALS AND SPECIALTIES AND THE MANNER OF PAYMENT FOR PROFESSIONAL SERVICES

Mr. President and Members of the House of Delegates:

The report made in 1951 to this House of Delegates has been submitted to this Committee, which now includes members representing the Hospital Association. This Committee felt that paragraph one (1) of the 1951 report would not be found acceptable to the legal counsel of the hospitals, and have suggested that paragraph one (1) be resubmitted to this body, as written by Mr. Harvey Weiss.

Following is the report which is mentioned above with the exception of paragraph one (1) which has been rewritten:

This Special Committee, appointed for the purpose of considering the relationship between hospitals and specialties and the manner of payment for professional services, was finally called together after the feelings of the American Medical Association and the American Hospital Association were known. It was also felt desirable to know the feelings of the National groups of the specialties represented on the Committee as well as the desires of the local groups. It was felt that the Committee should recommend to the Medical and Chirurgical Faculty, that the following outlined conditions obtain in all relationships between radiologists, pathologists and anesthesiologists and the institutions in which they work either on a full-time and part-time basis. Although not specifically requested to do so, it was felt that these recommendations should also apply to physicians rendering physical therapy or responsible for the same.

1. *The Medical and Chirurgical Faculty recommends to hospitals that all specialists engaged in the fields of radiology or roentgenology, pathology and clinical laboratory work, anesthesiology and physical therapy (physicians) be given staff appointments in the same manner as given to all other physicians, in any given institution. The Faculty further recommends that financial or contractual arrangements made between the hospitals and the above specialists are to be recorded in writing, in duplicate, and a copy of these financial and contractual arrangements be given to the specialists.*

2. *That the Medical and Chirurgical Faculty recommend that all professional services rendered be billed for in the name of the physician rendering the service to the patient or responsible for such a service. In the event that there should be more than one member of the staff of any specialty, the bill should be rendered in the name of the responsible physician in that department of staff, i.e.: Consultation by Dr. Terwilliger and Staff, Production and Interpretation of X-Rays.*

3. *It does not appear to fall within the province of the Committee and Faculty to recommend to either individuals or institutions, the matter of finances specifically. It does not appear unreasonable to recommend that the manner of payment be a matter of local arrangements between the individual physician and an institution, preferably to be related primarily to the volume of work and teaching required.*

If approved these recommendations should then be sub-

mitted to all hospitals in this area, as well as the Hospital Administrators Meeting, which is to occur in Frederick, Maryland on May 23, 1952.

Respectfully submitted,
WEBSTER H. BROWN, M.D., *Chairman*
E. HOLLISTER DAVIS, M.D.
MERRELL L. STOUT, M.D.
HENRY L. WOLLENWEBER, M.D.

COMMITTEE FOR THE STUDY OF PELVIC CANCER

Mr. President and Members of the House of Delegates:

The Committee for the Study of Pelvic Cancer opened its office in the Medical and Chirurgical Faculty Building in September, 1951.

To date the following hospitals are cooperating in the study: Baltimore City Hospitals, Bon Secours Hospital, Church Home and Hospital, The Johns Hopkins Hospital, Lutheran Hospital, St. Agnes Hospital, Sinai Hospital, South Baltimore General Hospital, Union Memorial Hospital, University Hospital, Women's Hospital.

As of March 20th, 1952, 131 patients have been interviewed. The cases have been classified according to the delay period between the time of onset of symptoms and the time of correct diagnosis and adequate treatment. Classification of the first 131 cases is as follows:

No delay.....	39
Patient delay.....	57
Physician delay.....	10
Patient and physician delay.....	6
Institutional delay.....	2
Patient and institutional delay.....	1
Asymptomatic detected cases.....	8
Unclassified to date.....	8
	—
	131

Since November the Committee has held a meeting on the third Thursday of each month, at which selected cases have been presented and discussed. These meetings have been increasingly well attended.

This type of study is by necessity rather slow in starting and we feel it is impossible as yet to evaluate the work of the Committee. The Study is to be continued and a fuller report can be given at a later date.

Respectfully submitted,
RICHARD W. TELINDE, M.D., *Chairman*
J. MASON HUNDLEY, JR., M.D., *Vice-Chairman*
BEVERLEY C. COMPTON, M.D., *Secretary-Treasurer*
C. BERNARD BRACK, M.D.
ROBERT N. COOLEY, M.D.
CHARLES N. DAVIDSON, M.D.
EVERETT S. DIGGS, M.D.
HOWARD W. JONES, JR., M.D.
THEODORE KARDASH, M.D.
EMIL NOVAK, M.D.
MARK V. ZIEGLER, M.D.

COMMITTEE TO STUDY CERTAIN PHASES OF MEDICAL ECONOMICS

Mr. President and Members of the House of Delegates:

Following the Semiannual Meeting at Ocean City, the Committee was enlarged to include the following: Dr. Waldo B. Moyers, *Chairman*, Dr. Thomas K. Galvin, Dr. Frank Otenasek, Dr. Wolcott L. Etienne and Dr. Houston S. Everett. At the first meeting of the Committee a letter was sent to each Component Medical Society requesting each group to study the present income tax situation as it affects physicians. Replies were received from six of the County Medical Societies. Based on these replies and as a result of further study by this Committee the following recommendations were incorporated in a letter that was circularized to the physicians in the State which is self-explanatory.

"It has long been the feeling of doctors and other professional people that the present income tax laws, both state and Federal, are very inequitable and unfair to groups requiring a long and expensive period of training.

"A committee has been appointed by the Medical and Chirurgical Faculty of Maryland to study this problem. The members feel that very little can be accomplished without the support of the component medical society members and others facing the same problem. The Committee proposes that the Medical and Chirurgical Faculty, in conjunction with other interested groups, prepare and sponsor a bill, incorporating the following ideas, to be presented to the Maryland Legislature at the 1953 session:

1. The cost and compensation for time lost during training period be deductible from income tax over a suitable number of years.
2. Postgraduate and advanced training be deductible.
3. Setting up of a retirement plan taxable only on payment, which would allow an individual to prepare during his active years for his declining years.

STARTING THIS AT A SAFE LEVEL IS PROBABLY THE ONLY WAY TO EFFECTIVELY BRING THE PROBLEM BEFORE CONGRESS AT A NATIONAL LEVEL.

If you are in accord with the above ideas and would like to help in solving this problem, please sign your name and address below."

At the present time approximately seven hundred signatures have been obtained of which at least one half are from Baltimore City. Replies have not been received from six of the counties but the final total will be available at the meeting of the House of Delegates.

The Committee is of the opinion that its recommendations reflect the sentiment of the physicians in the State of Maryland in regard to the inequalities in the present income tax laws.

The Committee recommends the following:

1. *That the Medical and Chirurgical Faculty of Maryland make this problem one of its primary aims for the year and take the necessary action to prepare and present a bill to the Maryland Legislature incorporating the above ideas.*

2. *That the measures being taken by this Society in regard to*

this problem be presented to the House of Delegates of the American Medical Association in June, 1952, without any recommendation for action by that body.

3. *That an invitation be extended to other State Medical Societies to join in this movement.*

Respectfully submitted,

WALDO B. MOYERS, M.D., *Chairman*

WOLCOTT L. ETIENNE, M.D.

HOUSTON S. EVERETT, M.D.

THOMAS K. GALVIN, M.D.

FRANK J. OTENASEK, M.D.

JOINT COMMITTEE WITH THE BAR ASSOCIATION ON MEDICOLEGAL PROBLEMS

Mr. President and Members of the House of Delegates:

As a result of the request of the Baltimore City Bar Association, the Council authorized Dr. C. Reid Edwards, the Chairman, to appoint a committee to cooperate with the Bar Association.

Since that time, Dr. Edwards has appointed five members to serve on the Medicolegal Committee of the Medical and Chirurgical Faculty. The members of the Faculty Committee are now as follows: Dr. Louis Krause, Chairman, Dr. Conrad Acton, Dr. Leo Brady, Dr. Russell S. Fisher, Dr. Manfred S. Guttmacher, Dr. R. Carmichael Tilghman, Dr. I. Ridgeway Trimble, Dr. Henry F. Ullrich, Dr. Thomas Conrad Wolff and Dr. Charles A. Reifschneider. The Bar Association has the same number of members on its Committee.

There have been five meetings of the Committee. The Joint Medicolegal Committee has been divided into subcommittees as follows: (1) Symposia Management Subcommittee; (2) Subcommittee on Interprofessional Relations; (3) Subcommittee on Court Procedure.

Under the auspices of the Joint Medicolegal Committee and arranged by the Symposia Management Subcommittee, the following meetings have been held in Osler Hall, of the Faculty Building: (1) Symposium on *Drug Addiction*, Saturday morning, October 13, 1951; (2) Symposium on *The Doctor in Court*, Friday evening, December 7, 1951; (3) Symposium on *Medical Aspects Relating to Euthanasia*, Friday evening, March 28, 1952. All papers presented during these symposia have been, or will be, published in the Maryland State Medical Journal. The programs were well received and the attendance was gratifying. At the present time it is planned to have two additional symposia and the subjects are under consideration.

The following is quoted from Dr. Thomas Conrad Wolff's paper, *Expert Testimony from the Viewpoint of Industrial Medicine*: "That a properly classified panel of such Expert Medical Witness be nominated by the Medical Society for short periods of service, to be replaced by another such panel when the period of service has expired, and that the Doctors on such panels reply to calls for such service as a matter of civic obligation." As a result of this recommendation, the Council authorized the Chairman, Dr. C. R. Ed-

wards, to appoint such a committee to study the formation of a panel and report back to the Council. This is pending as the Chairman of the Council has written to the President of the Bar Association, and until his wishes are known on the subject, the appointment of such a committee is being held in abeyance.

It is the feeling of the lawyers and doctors that the meetings have served a good purpose so that there would be a better understanding between both groups in their relationships in the future.

Respectfully submitted,
 LOUIS KRAUSE, M.D., *Chairman*
 CONRAD ACTON, M.D.
 LEO BRADY, M.D.
 RUSSELL S. FISHER, M.D.
 MANFRED S. GUTTMACHER, M.D.
 R. CARMICHAEL TILGHMAN, M.D.
 I. RIDGEWAY TRIMBLE, M.D.
 HENRY F. ULLRICH, M.D.
 THOMAS CONRAD WOLFF, M.D.
 CHARLES A. REIFSCHNEIDER, M.D.

COMMITTEE TO COOPERATE WITH AMERICAN MEDICAL EDUCATION FOUNDATION

Mr. President and Members of the House of Delegates:

The attention of the Faculty is called to an article which will appear in either the April or May issue of the State Journal entitled, *Maryland Reports at Chicago*. This article points out the initial results of the A. M. E. F. campaign for the period of January 1, 1952, to February 14, 1952. It also points out that while Maryland did assume a prominent place in comparison with other states during that period, we were way down the list in 1951.

In Colorado in 1951, with a state membership of over 1100 members, over \$8,000 was contributed. This year in Indiana in one county alone where there were only 18 members in that county, there were pledges of more money than the total amounts contributed by the whole state of Maryland. Indiana's contributions in the first three months of this year totaled over \$20,000.

I doubt it necessary to emphasize the extremely important public relations, educational, political, and social significance

in the activities of the American Medical Education Foundation and its ultimate success. Some state societies have chosen to contribute rather substantial amounts directly to the Foundation, and others have chosen to stimulate an awareness of individual response by allocating funds for an adequate campaign to encourage every member's contribution. An adequate campaign cannot be carried on without adequate funds.

With the relative inexperience of the newly appointed Chairman of your state committee in such matters, and in view of the fact that the entire State Committee will have its first meeting after the delivery of this report, *I am leaving it to the discretion of the more experienced members of the Faculty and House of Delegates to suggest which plan would be advisable, pointing out that the consensus of the officers of the A. M. E. F. was that over a long period of time greater advantages could be accrued from stimulating individual member responsibility.* As if to substantiate this statement, I would like to point out that our total response this year of those contributors that came through the Faculty was due to an initial letter in January, 1952, from which we are still receiving contributions. This Committee has had no indication of the scope permissible in even mailing expenditures or advertising through a media designed to reach the physician.

I wish to express our appreciation of the cooperation from the secretarial staff of the Medical and Chirurgical Faculty, and of Dr. Yeager, Secretary of the Faculty, and the members of our county societies cooperating with this Committee. We may be slow in getting organized, but we are preparing for a long term program to support our Medical Schools.

Respectfully submitted,
 NEWLAND E. DAY, M.D., *Chairman*
 THURSTON R. ADAMS, M.D.
 WALTER E. BAETJER, M.D.
 J. H. BATES, M.D.
 STUART CHRISTILF, JR., M.D.
 H. V. DAVIS, M.D.
 CHARLES R. FOUTZ, M.D.
 J. STANLEY GRABILL, M.D.
 WILLIAM B. HAGAN, M.D.
 L. A. HOFFMAN, M.D.
 PHILIP A. INSLEY, M.D.
 ERNEST F. POOLE, M.D.
 THEODORE R. SHROP, M.D.
 M. H. SPRECHER, M.D.

The Scientific Program of the 1952 Annual Meeting will be continued in the September and subsequent Journals.

SPECIAL CURRENT NOTICES

INFORMATION OF EXTREME IMPORTANCE!

SELECTIVE SERVICE

R. WALTER GRAHAM, M.D.*

The following announcement by Col. C. Henry Stanwood, Maryland Director of Selective Service, has been received by this office and is submitted for your information:

Colonel Henry C. Stanwood, State Director of Selective Service for Maryland, today announced that instructions have gone out to all local boards to proceed with the classification and armed forces physical examination of all Priority Three Dentists and Physicians who were registered or who subsequently registered under Public Law 779—81st Congress (the Doctors and Dentists Draft Law).

Priority Three Dentists or Physicians are those persons who did not have active service in the Army, Air Force, Navy, Marine Corps, Coast Guard, or the Public Health Service subsequent to September 16, 1940, and who were under fifty (50) years of age at the time of registration. The initial registration of Priority Three Physicians, Dentists and Veterinarians took place on January 15, 1951.

At the earliest practicable date, local boards will mail to Priority Three Dentists and Physicians the Selective Service "Classification Questionnaire" and the "Initial Data for Classification and Commissioning in Medical, Dental and Veterinary Corps." Upon receipt of these completed documents, the local board will proceed with the classification of the registrant. Those registrants who are classified in a class available for military service, or who are classified as Conscientious Objectors available for assignment to civilian work contributing to the maintenance of the national health, safety or interest will be given an armed forces physical examination. These physical examinations will be scheduled at an early date. Information with respect to the probable date of induction of Priority Three Dentists and Physicians is not available at this time.

Local Volunteer Medical Advisory Committees will continue to advise the respective Maryland local boards regarding the essentiality or non-essentiality of the Dentists and Physicians in their civilian capacities.

* Chairman of the Medical Advisory Committee to Selective Service.

We would also like to call attention to Information Bulletin Volume III, No. 8, received from the National Advisory Committee to the Selective Service System, which states:

Essentiality in Community Practice

The Illinois State Advisory Committee is using a plan which the National Advisory Committee desires all State Advisory Committees to use in connection with declaring physicians and dentists essential to community practice where it is considered to be necessary to do so. Such men are declared essential for six months with the understanding that the Chamber of Commerce, mayor or whatever organization has supported the essentiality must show evidence in writing at the end of six months as to their efforts to obtain someone to practice in that community; otherwise, the deferment will not be renewed. Such evidence would be in running ads in medical journals, contacting placement agencies, etc.

* * * * *

SEMIANNUAL MEETING COMMANDER HOTEL, OCEAN CITY, NEW JERSEY

Friday, September 12, 1952

The members are urged to attend this meeting. The local Committee has arranged many interesting features—the clam bake luncheon, cruise or miniature golf tournament and a dance.

The Committee feels it is fortunate in having as the guest speaker at the Scientific Session in the afternoon, Dr. Wingate M. Johnson, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina, whose address, "Geriatrics in General Practice," will be a Trimble Fund Lectureship.

The House of Delegates will meet September 12th, at 9:30 a.m. and the Council will convene on Thursday, September 11th, at 8:30 p.m.

Pertinent data and programs for the Semiannual Meeting are being mailed to every member on or about August 22, 1952.

COURSE IN THE BASIC SCIENCES AS THEY APPLY TO THE PRACTICE OF MEDICINE

Bressler Lecture Hall—second floor

29 S. Greene Street, Baltimore, Maryland

The Post Graduate Committee of the University of Maryland School of Medicine will again offer a course in THE BASIC SCIENCES AS THEY APPLY TO THE PRACTICE OF MEDICINE. The first lecture, "Mechanism of the Action of Drugs," will be given by Dr. John C. Krantz, Jr., on September 24, 1952.

Thirty-two meetings, of two hours each, will be held on Wednesdays at 4:00 p.m., except during University holidays. Registration is urged in advance. A detailed prospectus of the course, further information and application blanks are available from the office of the Post Graduate Committee, 6th floor Bressler Building, 29 S. Greene Street, Baltimore 1, Maryland. Registration will be held on September 22 and 23, 1952, from 9:00 a.m. to 4:00 p.m., at this address.

* * * * *

CANCER SECTION

Initial Meeting, Friday, October 3, 1952, 8:00 p.m.

Top Cottage, The National Institute of Health
Bethesda, Maryland

The first official meeting of the Cancer Section of the Baltimore City Medical Society will be held in Top Cottage at the National Institute of Health, Bethesda, Maryland, on Friday, October 3, 1952, at 8:00 p.m.

We are extremely fortunate in having as our host, Dr. John R. Heller, Director of the National Cancer Institute, who is planning a most interesting scientific program. The National Cancer Institute, judged by all standards as to personnel, achievement, and facilities, is undoubtedly one of the world's most celebrated centers for research in the field of neoplastic disease. A favorable opportunity is thus provided to visit the National Cancer Institute and meet the members of its staff. The program will be as follows:

1. Experimental Work on Carcinoma of the Thyroid. Dr. Harold Morris.
2. Experimental Aspects of Cancer of the Cervix Uteri. Dr. Edwin Murphy.
3. The Program of the National Cancer Institute. Dr. John R. Heller.

The members of the Medical and Chirurgical Faculty are cordially invited to attend.

* * * * *

THE SEMIANNUAL MEETING OF THE

WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Will Be Held On Friday, September 12, 1952, from
10:30 A.M.—12:00 Noon

At The Commander Hotel, Ocean City, Maryland

Mr. Leo E. Brown, Director, Department of Public Relations and Assistant to the General Manager, American Medical Association, Chicago, Illinois, will speak on "Winning Ways With Patients."

Every doctor's wife is cordially invited to attend this meeting

Nobody's too busy to REGISTER

Nobody's too busy to VOTE!

DON'T NEGLECT YOUR PRACTICE IN CITIZENSHIP!

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, July 4-31, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL.	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County.....	4	—	3	—	17	2	5	6	1	—	—	—	—	32	—	7	—	—
Anne Arundel.....	7	—	—	2	2	—	1	1	1	—	—	—	—	11	—	2	—	1
Howard.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Harford.....	1	—	3	1	6	—	—	1	1	1	—	—	—	1	—	1	m-6	1
Carroll.....	—	—	—	—	4	—	2	—	—	1	—	—	—	2	—	—	—	3
Frederick.....	1	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	—
Washington.....	—	—	—	—	—	—	—	—	—	—	—	—	—	6	—	2	—	2
Allegany.....	—	—	1	—	2	—	—	—	—	—	—	—	1	8	—	1	d-1	2
Garrett.....	—	—	—	—	3	—	—	—	—	—	—	—	—	—	—	—	—	—
Montgomery.....	2	—	4	—	8	—	6	—	—	—	—	—	—	14	1	2	—	—
Pr. George's.....	3	—	1	—	3	—	—	—	4	2	—	—	—	6	—	1	—	2
Calvert.....	—	—	—	—	1	—	—	—	—	—	—	—	—	1	1	—	—	—
Charles.....	1	—	1	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—
Saint Mary's.....	—	—	—	8	—	—	—	—	1	—	—	—	—	1	1	—	—	3
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Kent.....	—	—	—	—	—	1	—	—	—	—	—	—	—	3	—	—	—	—
Queen Anne's.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—	—
Caroline.....	—	—	—	—	7	—	—	—	—	—	—	—	—	2	—	3	—	—
Talbot.....	—	—	—	—	1	—	—	—	—	—	—	—	—	3	—	2	—	1
Dorchester.....	—	—	—	—	3	—	—	—	1	—	—	—	2	1	—	2	—	2
Wicomico.....	—	—	—	—	2	—	—	1	—	—	—	—	—	1	—	13	—	5
Worcester.....	—	—	—	—	1	—	3	2	—	—	—	—	—	2	1	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	1	t-1	1
Total Counties.....	19	0	13	11	60	3	17	11	9	4	0	0	3	101	5	39	—	23
Baltimore City.....	45	0	13	7	15	2	41	3	0	8	3	0	10	125	5	660	tr-1	13
State																		
July 4-31, 1952.....	64	0	26	18	75	5	58	14	9	12	3	0	13	226	10	699	—	36
Same period 1951.....	48	2	39	21	748	2	134	4	8	17	0	2	24	254	24	544	—	18
5-year median.....	56	8	12	—	71	5	89	20	13	18	4	2	131	220	83	688	—	27
Cumulative totals																		
State																		
Year 1952 to date.....	2711	7	815	151	9015	66	836	22	18	800	14	11	144	1672	103	4206	—	454
Same period 1951.....	2638	29	825	164	4997	43	3487	17	27	701	8	17	312	1651	208	4109	—	350
5-year median.....	3005	139	374	—	2859	88	1129	25	35	847	18	29	769	1711	844	4272	—	454

d = amoebic dysentery.

t = tularemia.

tr = trichinosis.

m = malaria reports from Aberdeen Proving Grounds, contracted outside the U. S. A.

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SCIENTIFIC SESSIONS

Tuesday and Wednesday, April 29, and 30, 1952

Part II

Pages 429-481

Scientific Sessions

TOO BIG A JOB FOR ONE YEAR¹

PAUL B. MAGNUSON, M.D., L.L.D., D.Sc.²

When I received your kind invitation to give the annual Trimble lecture, I wrote Dr. Compton that I had several pretty sound medical papers worked up on the causes of pain in the lower back—I've been working in that field for more than 40 years—but that the ladies might be much more interested in some information on the President's Commission on the Health Needs of the Nation. So, in deference to the ladies, I am going to talk about the latter topic.

Last November, without a word of warning I got a call from the White House that the President of the United States wanted to see me. I took the train from Chicago that night, and the next morning met with the President. The President laid the cards right on the table. He said he was deeply concerned with the health of the American people in these trying days of all-out mobilization. He said he had made certain proposals to bring more and better medical care to the people, but these proposals had precipitated an emotional argument which had clouded the issue. The President said he was not necessarily committed to any one plan—if any group could come up with a better series of proposals than the ones he advocated, he would be the first to support them if they would insure better health for all the people.

For that reason, he said, he had decided after long deliberation to set up a Presidential Com-

mission to get at the facts. He offered me the chairmanship, and promised me an absolutely free hand in choosing the members of the Commission.

For the record, I want to say that I had absolutely no interference or pressure in selecting this Commission. All the members were suggested by me to the President after I considered their interests, ability and fair-mindedness. No one in the White House ever raised a question as to whether an appointee was a Democrat or a Republican, or whether he was in favor of the President's plan or not. Maybe I'm prejudiced, but I think this is the best of a long line of Presidential Commissions. It is absolutely free of politics; we have laid down a rule that no one from a Government agency shall be in any policy-making job.

Of course, we have an awfully big job ahead of us. Let me read you just a bit from the Presidential directive.

The Commission has one major objective, the directive reads. "During this crucial period in our country's history, it will make a critical study of our total health requirements, both immediate and long-term, and will recommend courses of action to meet these needs. The Commission is authorized and directed to inquire into and study the following:

(a) The current and prospective supply of physicians, dentists, nurses, hospital administrators and allied professional workers; the adequacy of this supply in terms of the present demands for service; and the ability of educational institutions and other training facilities to provide such additional trained persons as

¹ I. Ridgeway Trimble Lectureship presented at the Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland, on Wednesday evening, April 30, 1952, in Osler Hall.

² Chairman of the President's Commission on the Health Needs of the Nation, Washington, D. C., and Chicago, Illinois.

may be required to meet prospective requirements.

(b) The present ability of local public health units to meet demands imposed by civil defense requirements and by the needs of the general public during this mobilization period.

(c) The problems created by the shift of thousands of workers to defense production areas requiring the relocation of doctors and other professional personnel and the establishment of additional facilities to meet health needs.

(d) The degree to which existing and planned medical facilities, such as hospitals and clinics, meet present and prospective needs for such facilities.

(e) Current research activities in the field of health and the programs needed to keep pace with new developments.

(f) The effect upon the continued maintenance of a desirable standard of civilian health of the actions taken to meet the long-range requirements of military, civil defense, veterans' and other public service programs for medical personnel and facilities.

(g) The adequacy of private and public programs designed to provide methods of financing medical care.

(h) The extent of Federal, state and local government services in the health field, and the desirable level of expenditures for such purposes taking into consideration other financial obligations of Government and the expenditures for health purposes from private sources."

A mighty large order! When I met with the Commissioners at the first meeting in the middle of January, there was a collective sigh when I read that directive. However, we decided to go around the table and get each other's ideas on how we could tackle the job.

The Chairman led off. I told my fellow members that I had practiced medicine for forty years and still had implicit confidence in the good, common sense of the American people when a straight proposition is put before them and they are given reasons. I said it was our job

to put such a sound proposition before the people. We were not promoting anything—we were trying to find out. I said I felt then, as I have felt always, that there is nothing to the practice of medicine except three things: the prevention of disease, the cure of disease, and the returning of the patient to a useful situation in life.

I told the medical members of the Commission that we could not hold to the proposition that there can be no improvement in our profession, because there has been improvement, tremendous improvement, every year. Conditions have changed a great deal since I started practicing medicine, I said, and maybe the medical profession has been guilty of denying the existence of problem areas without looking at the many sides of the question. As long as one person in this country dies needlessly of illness or disease, there is a problem.

Then I turned to the other members of the Commission—outstanding citizens from the ranks of labor, agriculture, education, dentistry, nursing, as well as medicine, and asked them for their views as to the job of this Commission. I wish I had time to quote from all of them, for they together epitomize the free-swinging, democratic spirit of this group. I cannot resist a few selected quotes.

Walter Reuther, who came up from the other side of the tracks to the Presidency of one of the country's largest unions, made this moving statement:

"I have had the opportunity, and it was not one of my own choosing—to be in about five or six different hospitals during the last five or six years. I was at Duke Hospital. They took care of me very well down there. I wish every American could get the kind of medical treatment I got. I think every American is entitled to it.

"If we can forget about the ideological aspects of this controversy and really talk as people, I think we will agree that the doctors of America are just like everybody else. They want to make their contribution at trying to make America a better place for people because really that is

what the whole fight in the world is about. *It is about people.* We want the kind of America where people can have an opportunity to make their contribution without any restrictions on their growth. We want every child to have the right to grow up strong in mind and body no matter what side of the railroad tracks he is born on. I believe we can look at this problem in terms of what are the health needs of America, what are our facilities to meet those needs, how large the deficit is and then sit down and say, 'O.K. This is the problem—how do free people solve that problem?' ”

Clarence Poe, editor of "The Progressive Farmer," one of America's great farm journals, had this to say:

"The average man in America today knows now, more vividly than ever before, how valuable modern scientific knowledge has become in protecting the health and the life of his wife, his children and his family, and the determination to have it. It seems to me that the most important job before our Commission is finding some way, some form of insurance or some kind of help by which the poorest people of the country can get proper medical and hospital care. I imagine I speak for the farm folks on that."

And finally, some wise words from a doctor—Russel V. Lee, who has a big group clinic out in Palo Alto, California:

"I hope we will regard this activity primarily as a research product and not bring to it too many preconceived ideas. I have worked on a similar affair in California for a year. At the end of that time, I was impressed with what I didn't know and didn't have the answers for.

"I am certainly not one of those who thinks there is no need for such activities as this. The need for this Commission's work comes curiously enough from the success of medicine and all medical activities. Up until 1910, it was demonstrable that you were just as well off if you had no medical care as far as longevity was con-

cerned, yet every decade since that time there have been enormous advances in medicine until today it is quite likely you are much better off if you have adequate medical care. I think we have available potentially the medical knowledge and resources to make this country a heaven on earth as far as medical conditions are concerned.

"Our principal task is to point out how these resources should be applied to the problem. It is perfectly certain that most of the infectious diseases can be completely eradicated with what we have now. There is no sense in having venereal disease. A year of proper activity would wipe out syphilis and gonorrhea.

"New fields in medicine have developed with great rapidity, but that puts a tremendous obligation upon medicine. And I mean all the ancillary services, too—hospitals, nurses, technicians, etc.—to render what we have available to the public. The public is demanding it. That is something we must realize.

"I think perhaps the ordinary citizen exaggerates in his own mind the miracles that medicine can do, but when the father of a family whose children are ill believes there is available somewhere the medical knowledge and facilities to save the lives or prevent the crippling of his children, he is certainly going to demand that he get it regardless of what his social status is. He may put up with poor housing and a number of other things, but if it is life or death for his family, he will not put up with it."

All right, we have this big job. How are we going about tackling it?

First of all, the Commission has divided its work up into three parts:

1. Assessing the total health resources for the country. A staff of technicians has been working on this since the middle of January—digging into the complexities of number of health personnel, hospital beds, health education facilities, health insurance coverage, costs of medical care, and so on. Sometime in the fall, the Commission hopes to bring out a monumental and important

volume entitled: "The Health Resources of the American People." We think it will be the first completely factual, unbiased analysis of our total health strengths and shortcomings.

2. The second part of the tri-partite working plan, estimating the health needs of the American people, is now keeping us busy day and night. We have scheduled a series of more than 25 panels on every imaginable phase of medical care. Each of these panels is an all-day give-and-take session—no formal testimony and no ceremonial parading of witnesses. The country's ten or twelve top experts in each of the fields sit down for a day behind closed doors and bat the problem around. The panel findings are then digested and presented to the full Commission. By the time of the final panel somewhere around the last week in June, the Commission will have heard several hundred top medical and lay experts from every section of the country give their off-the-cuff views on everything from promotion of health and prevention of disease to care of the mentally ill and the status of rural medicine.

We held seven all-day panels in April, and I attended every one of them. The second week in April, we had separate one-day panels on general practice, specialization and group practice, and I want to say to you without one ounce of exaggeration, they were the finest, most stimulating discussions of the subjects I have heard in 40 years of listening in at medical meetings. No holds were barred. As an example on the second afternoon we had the general practitioners and the specialists come in and have at each other. You should have seen the fur fly.

We have kept up that gruelling pace since then. In the last two weeks of April, we had panels on rehabilitation, regional medical plans, promotion of health and prevention of disease. The stenographic transcript of these April meetings runs to over 2,000 pages, and we have a lot more panels to go.

And that's not all in the health needs area.

Prior to these panels, the Commission held a series of formal hearings on aid to medical education and local public health units. We heard 16 experts give fact-packed testimony which filled more than 500 pages of the Commission's official records.

As a final step in estimating health needs, Commission members are now mulling over the idea of a series of field trips to get a close, realistic view of both the good and bad in medical care today. As an example, there is talk of a trip to rural Mississippi to find out just what medical care rural people get. In addition to talking to people on the spot, the Commissioners would visit country practitioners, look over local hospitals, study the state's regional medical plan, and so on. Another trip might take Commissioners to a defense-impacted area where they could observe the many problems created for providers of medical care by sudden shifts of population.

3. Finally, when all the health resources have been inventoried, and all the needs have been ascertained, the Commission will get down to the job of making its formal recommendations to the President trying, as far as possible, to fit its final proposals within the framework of the achievable health resources of the country.

Now I want to talk to you a bit about what is closest to my heart—taking care of sick people and preventing people from dying. In the five years that I was with the Veterans Administration, I had only one paramount concern—getting our veterans well again and returning them to society as useful, productive citizens. I wouldn't give you a million dollars for one inch of red tape in that operation, but I wouldn't take a hundred million dollars for the satisfaction I got in feeling that I helped in a small way to return thousands of veterans to good health.

It is true that we have made great strides in the past half century in the improvement of the general health of the American people. From an

average lifetime of 49 years in 1900, our life expectancy has risen by more than one-third to nearly 68 years at present. This is a singular tribute to the skill and devotion of the American medical profession.

However, as my friend Walter Reuther puts it, there must be no sacred cows in American life. He points out that the workers in his union make good automobiles, but they could make better ones. In like manner, we doctors are providing good medical care, but we could provide better medical care. We are not perfect. Those few in our profession who, ostrich-like, deny the existence of any health problems do their own profession and the American people a great disservice.

Let me give you an example. At one of our Commission meetings, we heard testimony from Dr. Howard A. Rusk who, in addition to being medical director of the Institute of Physical Medicine and Rehabilitation in New York City, is chairman of the Health Resources Office in Washington. The Health Resources Board has been making some intensive studies over the past several years of the total health requirements of the nation. Here are a few of the figures Dr. Rusk gave to the Commissioners:

1. There are estimated to be between 25,000,000 and 28,000,000 handicapped people in this country. This includes between nine and eleven million people with heart disease, probably a third of whom are severely disabled; about six million with arthritis; two and a half million with orthopedic disabilities; 1,500,000 hemiplegics; 600,000 amputees; 50,000 paraplegics, and so on down the line.

Dr. Rusk said a Health Resources task force report on rehabilitation showed conclusively that from two to four million severely disabled people could be gainfully employed if they received adequate training. With a dynamic program, 90 per cent of all severely disabled persons can do some type of gainful work. For example, in a survey of some six hundred paraplegic minors whose paraplegia had existed anywhere from six

months to 21 years, 80 per cent were placed back in gainful occupations after an average training time of 4 months.

He told some moving stories—for example, of a boy with both hands off who was suicidal when he entered the New York Rehabilitation Institute. That boy, who has a wife and three children, is now a mechanic's helper at Sperry Gyroscope handling 40-pound boxes.

Dr. Rusk pointed out an amazing thing—out of a thousand people his Institute had trained and placed in industry in the last 18 months, only four had to be replaced.

We had the same experience in the Veterans Administration. In the Minneapolis hospital, we had 169 patients who had been bed-fast anywhere from two to fifteen years. We instituted a rehabilitation program up there with a group of doctors. It takes a group to do it—the orthopedic surgeon, whom I mention first because that is my category, the neurologist, the psychiatrist, the psychologist, the internist, and everyone else they want to call in.

That group went to work on those 169 patients who had been in bed for so long. Inside of nine months, fifty per cent of them were back earning a living. At this time, four years after the program started, only nine of those patients are still bed-fast!

Now, remember this—until this program had started, nobody had paid any attention to them, nobody had given them any help, nobody had guided them, nobody had taught them what they could do toward making a living with what they had left. Sure, it was a tough job. Many of them had arthritis, and I know arthritis hurts, but it doesn't hurt half as much when you're busy as it does when you're just loafing, sitting in bed just thinking about your suffering. Getting these people back to work in itself is enough to give them a new hope, and when it comes to the humanitarian side of it, it is a most important part of medicine.

Dr. Rusk also gave the Commissioners these additional findings from various studies by his

Health Resources office:

2. One out of every 18 persons in the United States is now suffering from some form of mental illness, and one out of every ten persons will need psychiatric care at some time in his life.

3. About 20,000,000 people now alive will die of cancer unless new treatments and cures are found.

4. Two persons out of three in the United States need financial help to meet the costs of serious illness.

5. Sickness absenteeism costs the nation the full time of 2,000,000 workers each year.

6. The nation's medical schools are faced with a serious financial crisis. Their deficits in 1948 totaled \$10,000,000 and are running higher today.

7. Nearly 50,000 nurses over and above those now in sight will be required by 1954 to meet both civilian and defense needs.

8. Nearly 30 per cent of our citizens live in communities in which there are no full-time local public health services.

When problems such as these exist, can we say there is no room for improvement? We all know of areas where a better quantity and quality of medical care can be given.

Can we do the job of surveying the health needs of the nation in the brief year allotted to us? I don't think we can do an absolutely comprehensive job, but I think we will come forth with some solid facts and recommendations in December. However, there is feeling among some of the Commissioners that this is really a five-year job which will change from year to year. If this Commission is to be of any permanent value, it should be a continuing Commission on the basis of the interest of the medical profession and the public to put all the information together that we can gather.

We need the cooperation, in our difficult task, of both the medical profession and the general public. As *The New York Times* said recently:

"It would be tragic indeed if full cooperation is not given to them (the Commissioners) in their efforts."

I didn't want this job in the first place. I have had my heart set on establishing a physical medicine and rehabilitation institute in Chicago before I retire from practice, and my present duties with the Commission have postponed that work. However, I could not in all conscience refuse the President's call to duty. I suppose I've got a reputation by now as a pretty frank talker, so let me quote to you what I told the press the day I was sworn in on this job; and I now quote:

"I believe that my professional brethren know that I am interested in no way in politics. I took this position, which is an unenviable one, to see if information could be gathered from all sides and all shades of opinion to make a cohesive story so that both the laity and the profession could understand the difficulties and hazards of the distribution of health services to the people of America, and to see if there is any way to improve conditions without interfering with the whole economics and ideals and progress of American medicine. I think it can be of great educational value to the American people to have a Commission discuss these things openly and freely, and without malice."

I have high hopes for this Commission. In the past few years, there has been an excess of emotion and charges and counter-charges about this whole health problem. I agree with *The Washington Post* that, in this bitter dispute, the forgotten man has been the citizen in need of more and better medical care. If this Commission can inject some light where too much heat has prevailed in the past, it will help signalize a desperately needed moving forward in bringing better medical care to all Americans.

Thank you again for the opportunity to share my problems with you.

"Vote As You Please—But Please Vote November 4th."

YOU AND YOUR A. M. A.*

You Are the A. M. A.

WALTER B. MARTIN, M.D.¹

It is a great pleasure to be here today. This is the place of my medical birth. Forty years ago I came here to begin the study of medicine. It is satisfying to return to old scenes, to greet old friends, and to revive memories of my great teachers. I want to thank you for granting me this pleasure. I am particularly gratified to have a place on your program, and to have the opportunity to talk with you about some of the common problems of your society and the American Medical Association. Medical organizations have their place in society, and these organizations must concern themselves with the economic and social aspects of medicine, as well as with the science and art of medicine.

The science of ecology deals with the effect of environment on an organism. That organism may be an amoeba in its primordial bog, the American buffalo on the western plains, or the body of American medicine. Certainly there are many economic social and political forces that now influenced and will influence the environment of medicine for good or evil. The future quality and quantity of medical care, its availability, and its cost, will be determined by the direction and control of environmental factors. Medicine, to flourish, must have a favorable environment.

Men group themselves together to improve and protect their environment. In so doing they may be motivated by selfish or altruistic purposes. What of medicine? The American Medical Association is the largest and most powerful

medical group in the world. Its fundamental policy is expressed in its constitution, and code of ethics. Article Two of its Constitution states that "The objects of the Association are to promote the science and art of medicine and the betterment of public health." Certainly no greater medical objective could be formulated. How well have we accomplished this purpose? How well will we in the future continue to work for the betterment of the health of the public, rather than for selfish ends? This is for you as physicians to decide, for you or the American Medical Association.

The American Medical Association is a federacy of state associations, with no authority to control or direct them. The component county societies are autonomous units and they elect the delegates to your state conventions. The states in turn elect delegates to the House of Delegates of the A. M. A. This House of Delegates is the policy-making body of the A. M. A. It is made up of representatives of the several states and territorial associations, with the addition of one representative from each of the scientific sections, one from each branch of the armed forces, and one from the Veterans Administration. It is truly a representative body that elects its speaker and formulates its own rules of procedure. Any member of the A. M. A. may listen to the proposals and debates in the House of Delegates. All reports and all resolutions introduced into the House are referred to Reference Committees of the House for detailed consideration. Any member of the American Medical Association may appear before any one of these reference committees and present his views for or against the matter under consideration.

* Papers presented on Tuesday morning, April 29, 1952, at the Annual Meeting, Medical and Chirurgical Faculty of Maryland.

¹ Norfolk, Virginia, Member of Board of Trustees of the American Medical Association.

The House of Delegates chooses the elective officers of the Association by secret ballot. The members of the Board of Trustees are elected by the House of Delegates in the same manner. Their total term of office is limited by our Constitution. Of the eleven members of the present Board of Trustees, there are only three who were serving on that body when I became a member less than five years ago. It is sometimes charged that the A. M. A. is controlled by a small group of reactionaries, that it is ruled by a hierarchy. If so, it is a strange one, for it cannot perpetuate itself nor can it exert punitive power over the state or county societies. The state societies elect the delegates who choose the Board of Trustees, and who formulate the policies of the A. M. A. If you are dissatisfied with the policy of the A. M. A., or perhaps its lack of policy, it is possible for you to change that policy, for you are the American Medical Association.

How does it work for the betterment of the health of the public and the advancement of the art and science of medicine? It operates through ten councils, five bureaus, and other special departments. It publishes a weekly *Journal*, the most widely circulated and I believe, the best medical journal in the world. In addition, it publishes nine special journals of great interest.

Dr. Howard, in his discussion, has outlined for you the organization of the A. M. A. headquarters and has described some of the activities of its several councils and bureaus. They are concerned with improvement in medical education in both the undergraduate and postgraduate field, with the quality of foods, drugs and appliances, with exposure of frauds and protection against industrial hazards, and with extension of medical facilities and medical care.

The A. M. A. is also constantly engaged in careful analysis of proposed legislation, particularly in the Federal field that may affect the future medical welfare of the American people. These are only a part of the activities that Dr. Howard has described to you.

I would like to discuss with you certain of the

policies of the A. M. A. You should know what its policies are and why they are being followed. If you believe they are sound, you should support them. If you think they are unsound, you should, through the medium of your local and state society, oppose them. If you have better policies, you should advance and urge them. The one thing you should not do is to ignore them since they are at present your policies.

We are often urged to formulate an overall national plan, a blueprint, if you please, for a system of medicine that would provide for all of our health needs. Such a plan has been proposed by Mr. Truman, and his aides, and presented to the Congress as the Wagner, Murray Dingle Bill. Study that bill carefully, its administrative features and its methods of financing, as well as its declaration of purpose, since it is the pattern of many other bills bearing on medicine. We believe that it is foolish and impractical to attempt to blueprint a system of medicine for this country, with its vast area, varying population density and diversity of social economic and medical needs. Neither the Federal Government nor the A. M. A. is capable of such an endeavor.

It is as foolish as the proposal contained in a bill several times introduced into the Senate, to appropriate one hundred million dollars, and to direct the President to assemble at a suitable place in the United States the outstanding scientists of the world and to direct them to find the cause of cancer. I am sure you believe as I do, that medical progress does not come about in that manner and that the control of cancer will not be accomplished by presidential fiat.

Progress in the social-economic aspect of medicine must come about as in scientific medicine by study, research and experimentation. In this connection one of the most valuable bureaus of the A. M. A. is the Bureau on Medical Economic Research.

To advance, however, we must establish certain principles and state at least tentative objectives. The first of these principles and it is

hardly necessary to state it here in the "Free State," is that governments are justly created by the people and that any bill that undermines or threatens to undermine our constitutional guarantees should be opposed. We must not trade our future security against undue Federal power for a pleasing or laudable immediate accomplishment.

What are our objectives and how do they apply to some of our immediate problems? We desire to continue the improvement in the quality of medicine, and to extend its quantity and distribution. We wish to lower the economic and geographical barrier that separate parts of our population from good medical care. We desire to preserve a sense of the responsibility of the patient for his own health, and the freedom of the physician to practice medicine in accordance with good teaching and sound ethics. It is our purpose to protect the freedom of medical teaching, medical research and medical practice from political control and to stimulate in every way the further advance of the science and art of medicine.

It is not enough to establish principles and objectives; these must be translated into action when particular problems arise.

We have urged the consolidation of the widespread medical activities of the Federal Government, with the exception of the medical service of the Armed Forces and the Veterans Administration. We opposed that portion of the Hoover Report that included these agencies, since we believed that total consolidation would interfere with the primary mission of the medical service of the Armed Forces, and that the inclusion of the Veteran medical service would not accomplish any real economy.

We have urged before the Congress that it define the responsibility of the Federal Government to various groups of its medical beneficiaries. At present the situation is utterly confused. We have repeatedly pressed for a National Hospital Board empowered to pass upon the need for and location of new Federal

Hospitals and to allocate beds in existing hospitals according to the needs of the several services. It is in this area that real economy can be accomplished.

We have opposed many bills because of administrative features. While the purposes of many of these bills, as stated in their preamble, have been highly desirable, their method of implementation would be destructive. The general pattern is usually the same, a laudable purpose, a blank check on the Federal Treasury, a Federal Administrator, and state participation on the basis of a state plan acceptable to the administrator. The administrator is granted the power to issue such regulations as *he* deems necessary to carry out the purpose of the act. These regulations unless specifically challenged in Congress, in six months become law. If the state does not bow to the will of the administrator, they are denied access to this particular grant, although they continue to pay their share of taxes into the Federal treasury. In most of these medical welfare bills, access to the courts on equality with the administrator is denied.

We have opposed Federal aid to medical education. The danger of political or ideological control of education is a constant threat to the integrity of a democratic form of government. We do not believe that it is possible to provide Federal aid to medical education on a broad scale so safe-guarded that the integrity of education will not be seriously threatened. We are fully aware of the financial problem of medical schools. Through the National Medical Education Foundation we hope to help resolve some of these difficulties.

I would remind you that none of you here paid the full cost of your medical education, and that your debt is past due. One hundred dollars each year for ten years, from each debtor, would provide abundant funds to meet the present operational needs of the medical schools and would yet repay only a portion of the debt that you owe.

The A. M. A. has consistently urged the ex-

tension of public health service to all of the people. We have not supported plans that would deprive states and localities of proper jurisdiction or that are not consistent with sound economic policy. We insist on a clear definition of the proper scope of medical practice and preventive medicine.

We believe that the American people are capable of protecting themselves against the catastrophic hazards of illness by voluntary insurance just as they protect themselves against other economic hazards by life, fire and automobile insurance. Through the Council on Medical Service every aid is extended in promoting voluntary plans. Already two-thirds of our population are covered by some form of protection in the health field. Maximal coverage can only be accomplished by more intense interest and activity on the local level.

Time does not permit a review of our policies in all of the fields of medical endeavor. I would

point out that we are deeply concerned with the whole problem of Federal subsidies and grants-in-aid not only in the medical welfare fields, but in all fields. The burden of Federal taxation is becoming insupportable. Local sources of revenue either by gifts or taxation are drying up. The deadly cycle of taxation, Federal subsidy, higher taxation and increased Federal power, even now threatens to undermine our form of government and destroy our freedom.

Only by revival of a sense of local responsibility and an insistence on maintenance of local control can the drift to Federal dominance be checked. Your local societies and your state societies have a great responsibility in aiding in the cure of ills of the medical body politic. You can also exert your power and influence through the A. M. A. If its policies do not meet with your approval, you have the power to change them, for *you are* the American Medical Association.

The Structure and Functions of the American Medical Association

ERNEST B. HOWARD, M.D.*

MR. CHAIRMAN, LADIES AND GENTLEMEN:

The American Medical Association is housed in Chicago in a nine story structure occupying a large portion of an entire city block. Included within the building is a complete printing plant occupying the first three floors, and the offices and staff of the many different Councils, Committees, Bureaus and Departments that serve the Association. (Fig. 1.)

More than 136,000 physicians are now members of the Association. Their membership is dependent upon membership in 1,987 component

county medical societies and 53 constituent state and territorial medical associations. (Fig. 2.)

The component county medical societies constitute the basic structural unit of the Association. Each component society selects representatives to the state society who, in their turn, select representatives to the House of Delegates of the American Medical Association. These delegates are selected on the basis of one per thousand, or fraction thereof, American Medical Association members in each state society.

The House of Delegates is the policy making body of the Association and conducts its business at two sessions held each year. It elects a Board

* Assistant Secretary of the American Medical Association.

of Trustees of nine, and a President and President-Elect who also serve on the Board. During the interim between meetings of the House of Delegates the Board of Trustees conducts the

representation of its members from the county through the state to the national organization.

In addition to the Board of Trustees the House of Delegates elects members for its "Standing



FIG. 1. American Medical Association building (9 story), 535 North Dearborn Street, Chicago, Ill.

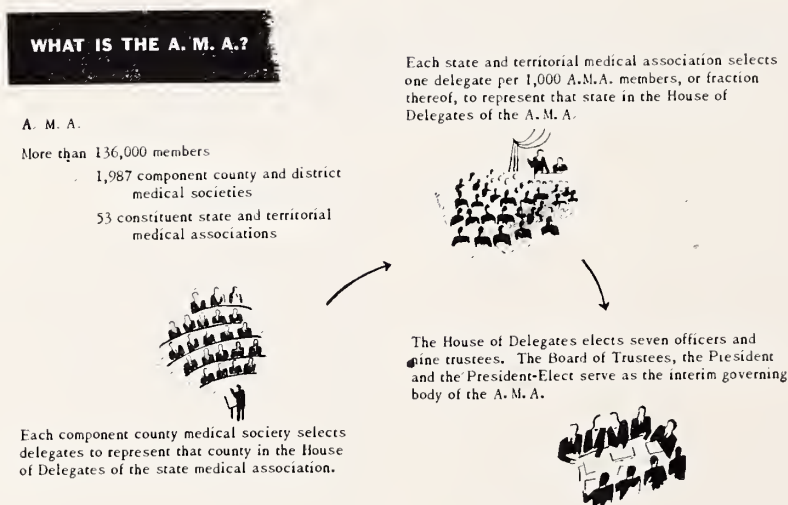


FIG. 2. What is the A. M. A.?

affairs of the Association but all matters of policy established by the Board are referred to the House of Delegates for final approval or disapproval. Thus, the American Medical Association is a democratic organization based on

Committees." (Fig. 3.) These committees include the Judicial Council, Council on Medical Service, Council on Medical Education and Hospitals, Council on Scientific Assembly and Council on Constitution and By-Laws.

The Judicial Council is the "Supreme Court" of the Association. It adjudicates controversies in all questions involving the Constitution and By-Laws, principles of medical ethics to which the American Medical Association is a party, controversies between two or more constituent associations or their members, and it has original jurisdiction in various other matters. In addition, it serves as the last Court of Appeal for problems arising within the component and con-

Medical Education. Today a large staff provides inspection service for internship and residency, medical schools and many other services concerned with the Council's program.

The Council on Medical Service is conducting essential research in this broad field. Committees on Federal Medical Service, Prepayment Hospital and Medical Service, Maternal and Child Care, Hospital and Physician Relationship, Indigent Medical Care and Medical Care

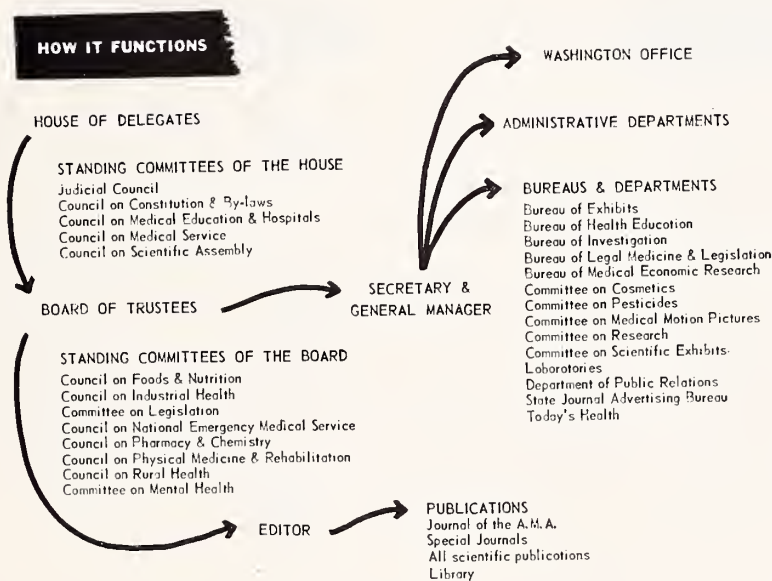


FIG. 3. How it functions

stituent associations. In considering questions as an Appellate Court it considers only questions of procedure, not of fact.

The Council on Medical Education and Hospitals is one of the older Councils of the Association. To it is due much of the responsibility for the vast improvement that has occurred in medicine in this country since 1910. Today seventy-nine medical schools—all of the existing medical schools—are approved by the Association and are providing medical instruction second to none in the world. This situation is the result of a vigorous program of inspection of schools, publication of informative material, careful guidance and persuasion, and the dedicated services of the members of the Council on

in Industry are making continuous studies in these important fields.

The Councils on Constitution and By-Laws and Scientific Assembly are concerned with amendments to the Constitution and preparation of the scientific programs respectively.

The Board of Trustees, like the House of Delegates, also carries on its operational responsibilities through the appointment of committees and councils. The Committee on Legislation for example, studies all new federal bills and recommends suitable action to the Board of Trustees.

The Council on Rural Health has established close relationship with various farm groups, particularly the American Farm Bureau Federa-

tion and the National Grange, so that joint planning for medical care in rural areas can be developed. It is through the program of this Council that the doctor-farmer team has been more effectively used than ever before to improve medical service in rural areas.

A new committee on Mental Health has recently been appointed by the Board of Trustees to utilize the resources of the Association with respect to this enormous and important field.

The Bureau of Medical Economic Research has conducted numerous fundamental studies in this field and soon will publish a monumental study on medical service areas. The work of its Director, Frank G. Dickinson, has received wide acclaim.

The Bureau of Health Education headed by Dr. W. W. Bauer, one of the nation's top authorities in this field, is outstanding. Its publications in the field of health, its radio and tele-



FIG. 4. Where the money comes from

The Washington office maintains close relationship with Congress. It supplies information to Congressmen, Senators and many Washington agencies and keeps the Board of Trustees and the Chicago office informed of developments as they occur in the Congress.

Many bureaus and departments as outlined in Fig. 3 carry on important functions but time will allow only brief mention of a few.

The Committee on Medical Motion Pictures has the largest file of medical motion pictures in the world. It has established a joint program with various government agencies to more effectively service foreign nations who are particularly eager to receive medical information from this country.

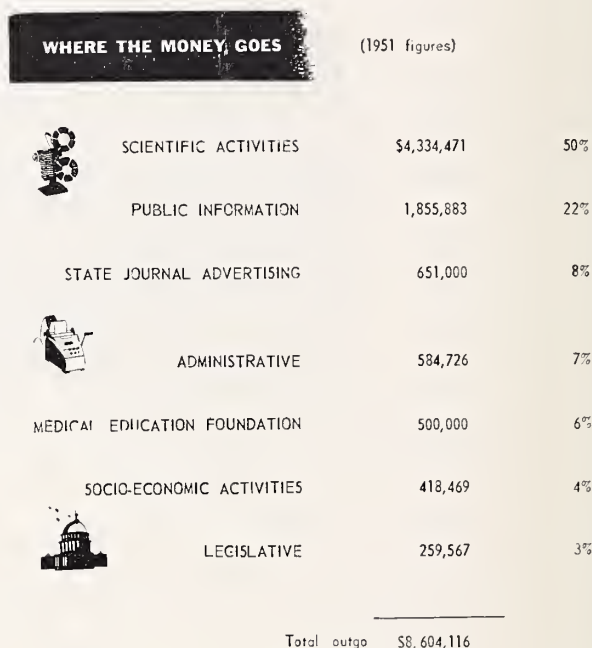


FIG. 5. Where the money goes

vision programs, its joint programs with the National Education Association in the field of school health and many others, have contributed significantly to the nation's health.

The Department of Public Relations is relatively new. For some strange reason the American Medical Association has been immoderately modest and has failed to tell the American people and the medical profession of its tremendous service to the public. Pamphlets will soon be completed and distributed to the profession and the public telling them what the American Medical Association is and what it does. Many other pamphlets are in preparation—one on medical cost and another on public relations for

doctors' secretaries. They will add immeasurably to the Association's stature especially in relationship to the public. The other bureaus and departments of the Association all deserve mention and a description of their activities, but time does not permit. They, too, provide essential services that contribute to medical science and public health.

The scientific publications of the Association are, of course, well known to you. The Journal is the top medical publication in the world, and nine special scientific Journals are also top publications in their respective fields. In addition to the scientific journals the Association publishes a Quarterly Cumulative Index Medicus, the Standard Nomenclature and the Medical Directory.

Where does the money come from to finance these many activities? Fig. 4 shows the sources of income of the Association for 1951. It is noteworthy that prior to 1950 when dues were levied on American Medical Association members for the first time, the Association had to depend primarily on advertising revenues for its activities.

Fig. 5 indicates "Where the Money Goes." It should be noted that fifty per cent of the total budget for the year 1951 was expended for scientific activities. Twenty-two per cent was allocated for public information, a portion of which was directed against the present administration's campaign to promote the passage of a compulsory health insurance bill and other legislation designed to achieve the socialization of medicine. Many members will be surprised at the expenditures and receipts of the American Medical Association. It is a reflection of the Association's size and the great variety of its services.

The American Medical Association is the largest organization of physicians in the world, devoting itself to services to the profession and to the public. It deserves the strong support of every one of its members for, without that support, it cannot function effectively. In turn the officers and staff of the Association will continue to provide the information and assistance directly and indirectly to every member of the Association that has made it possible for the practice of medicine in the United States to be conducted on so high a level.

*Remarks of George H. Yeager, M.D.**

DR. GEORGE YEAGER: In the past, State Medical Societies have had a close working relationship with the American Medical Association without any type of financial obligation. The State Society in no way contributed toward the support of the A. M. A. I'm sure that many of you had the personal experience of going to an A. M. A. Convention on the assumption that your State membership card entitled you to all of the facilities and courtesy of an American Medical Association membership. Then you found that you were not entitled to attend the exhibits and certain facilities at the convention,

although you were classified as a member of the American Medical Association. You were required, if you were interested in participating in these affairs, to subscribe to a fellowship, as it was called in those days, which entitled you to the A. M. A. Journal.

In the past few years we have placed ourselves on a sound, financial relationship with the A. M. A. I hope personally that when the hue and cry of "socialism" and fear of the Government taking over our profession has quieted down to some extent, even though the financial pressures may diminish on the major association, that we will still have some type of dues payment and that the dues payment will

* Secretary, Medical and Chirurgical Faculty.

continue to entitle us to the journal of the A. M. A.

I don't know whether Dr. Martin and Dr. Howard are acquainted with the confusion that was created in most State Medical Association offices over the changing status of dues and fellowship during the past four or five years. I know that our offices were swamped with continuing complaints, continuing inquiries from the various members as to what was interpreted as a voluntary contribution; an assessment and separation of dues from fellowship. Finally a firm basis of paying your dues to the A. M. A. has been established. You are entitled to the journal and the term Fellowship has been eliminated.

I would go further. The relationships of the A. M. A. from our viewpoint have been entirely satisfactory. Certainly those of us who are connected officially with the State Society are amazed at the ramifications and extensive activities of the A. M. A. I would like to throw this out as a possible suggestion. I do think that the A. M. A. still needs to strengthen its relationship with the average doctor in the average community. Personally, I am embarrassed from the State level viewpoint at the number of our

members who do not pay A. M. A. membership dues. I believe that Maryland compares favorably with most States. However, there are quite a few members of the State Society entirely reluctant or unwilling to take the additional step of paying dues to the American Medical Association and becoming a member of the major organization.

I have wondered personally if the A. M. A. couldn't strengthen its position by having some type of regional meetings from time to time, similar to the American College meetings. The A. M. A., as it is now constituted has two major meetings a year, the semiannual and annual meeting, and certainly from the meeting viewpoint they are everything that could be desired. Nevertheless, I believe that most of us who have attended the College Regional meetings have been impressed by their effective programs; by the scientific content and the fact that from the regional viewpoint the average doctor seems to take a much more intensified interest.

I rather believe the A. M. A. might at least think of it from an experimental viewpoint and try one or two regional meetings to see if their relationships with the average doctor are not tremendously improved. Thank you.

QUESTIONS AND ANSWERS

DR. CHESNEY: There is time for a few questions from the floor. Because of my difficulty in hearing, I am going to ask Dr. Yeager to take over the business of hearing the questions and interpreting them through the other speakers.

DR. YEAGER: I don't believe you have been handed slips of papers but if any of you would care to ask questions, I will be glad to transmit them to either one of the designated speakers.

Q.: I'd like to ask if the Panel thinks it is the thing for a member of one of the component County Societies or State Society to hold office

in either one of those organizations, who refuses to pay dues to the American Medical Association.

DR. WALTER B. MARTIN: I think that is a problem of local determination. I might express my opinion on it as an individual. I pointed out in what I said to you that the A. M. A., has no punitive power over the State and County Societies. Obviously a man that you're going to elevate to office in your County or State Society ought to have a very broad outlook on medicine, much broader than just his local interest, and he ought to be anxious to participate in the affairs of medicine in this country through the

influence of his State or County Society on the National level. Now, we have no way to enforce such a requirement but I think each County Medical Society and each State Medical Society ought to take action in that respect and the action should be "NO."

DR. YEAGER: I might amplify that slightly. Again I would like to emphasize that the American Medical Association has not imposed any rules or regulations upon a State Society. They have left to the discretion of the State organization ways and means and manner of running their own organization. I think that is truly a democratic system. I wonder whether the A. M. A. might not at least develop some type of principle of guidance for the State Societies, at least to use for what it is worth. From the State level viewpoint I might add that no one other than a fully paid active member may hold any type of position in the State Society. Associate membership does not entitle him to hold office. Are there any other questions?

Q.: Every one of us have been receiving a certain amount of literature and the Medical Association goes to considerable expense in printing this literature and has asked us to distribute it in the office. Some we pay for and some we get gratis. Of course, before we can sell our profession to the public we must first sell it to ourselves. I think that the service of medicine is hardly a personal one of the doctors attending. We must have faith in the organization, faith in the American Medical Association that attends to certain things that we personally cannot attend to. Of course, even the Board of Trustees and the Members of the House of Delegates are practitioners just the same as every individual physician. The American Medical Association ought to impress us that it is largely a personal matter. If, in my office, I take three minutes to explain to a patient what the Government finds new and the reason that I oppose it myself, it seems to me that that sort of teaching of the public is worthwhile and worth a whole lot more

than if I take a pack of pamphlets and put in my office with a sign, "Please take one of these home." It is a form of advertising. I think the advertising that we can do is only by our individual word. If the patient is impressed with his own physician's point of view, he goes out and tells his friends what the doctor told him.

Our profession has not been one of advertising. It ought to be very carefully watched. That is the thing to think about. A physician ought to have complete confidence in the American Medical Association. It is much easier for me to take a bunch of pamphlets and put them in my office and let the patient take one than it is for me to take a minute or two in the office and tell the patient what we are up against and how we oppose it and why we oppose it.

DR. YEAGER: I'll have to make one comment and pass that on. I believe all of us are totally agreed with your theory, but unfortunately in practice—and I see Dr. Goldstein and Dr. Koontz, Dr. Finney, Dr. McLanahan in the audience and various people that have been interested in some of these problems. I think they will all confirm the statement that the average doctor is totally unwilling to take the time to discuss these problems with their patients or even with their confreres. They, for some reason or other feel that someone else should do the job for them. I have discussed it repeatedly with friends of mine and they make the rather inane plea that they want to be left alone, that they only want to practice medicine. After all, that is the philosophy that all of us are directing our efforts toward. If we can overcome this immediate crisis and pressure that has been placed upon us, we can devote our full energies to the practice of medicine. You will find in dealing with the great majority of doctors that they are totally unwilling to make any personal effort on any of these problems. Would you care to amplify on that, Dr. Martin?

DR. MARTIN: Only in one respect. We found an enormous number of doctors who are not familiar with the facts, consequently they

couldn't transmit information to their patients until they were informed themselves. The purpose of the facts are two-fold and I think your suggestion is absolutely sound. One is to give the individual doctor access to basic information and then he could discuss those matters with the patient and friends—"Now here is something on that, if you're interested," and give him a pamphlet. It was never intended that they were put on the office desk and just shoved out to the patients in the hope that a little seed would sprout from one of them.

DR. YEAGER: Any other questions?

Q.: I'd like to ask Dr. Howard if the A. M. A. still publishes a small pamphlet on medical ethics?

DR. HOWARD: We publish "The Principles of Medical Ethics."

Q.: Do you have to pay for that or would that be supplied to the County Medical Society?

DR. HOWARD: It varies, that depends on the quantities you want. We usually distribute quantities up to fifty free. Beyond that we may or may not. It depends on the size of the quantity requested.

Q.: I had in mind supplying a new man coming into the County Medical Society with a copy of the Medical Ethics.

DR. HOWARD: I think that is a good policy. Incidentally, we are preparing a new pamphlet for the public that will also be useful for physicians. It will be entitled "The Code Your Doctor Lives By," which will be distributed widely to the public and which will demonstrate to them the kind of ethics the profession requires. I think that is a very good suggestion that all new members certainly should read the Principles and have it with them.

STATEMENT FROM THE FLOOR: Mr. Chairman, I might say the A. M. A. gave a few hundred copies of the Medical Ethics to the Baltimore County Medical Association and we gave a copy to every member and also sent an abstract of the release on public relationship. That also was distributed free to every member of the Baltimore County.

DR. YEAGER: I believe the first pamphlet was recently revised and distributed on Medical Ethics. Is there another question? If not, I'll turn the meeting back to Dr. Chesney.

DR. CHESNEY: I'm sure you all join with me in thanking the members of the Panel for coming here to present this very interesting material. I declare this meeting adjourned and call attention that the Scientific Session will be resumed at two-thirty this afternoon in this hall.

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall

1211 Cathedral Street, Baltimore 1, Maryland

Friday, October 17, 1952, 8:30 p.m.

The Baltimore City Medical Society is fortunate in that the Maryland Heart Association has succeeded in arranging for Dr. Dwight E. Harken, of Boston, Massachusetts, and Dr. Colin M. MacLeod, of New York City, to be the speakers at the opening of the Fall series of meetings.

Dr. Harken will discuss "Surgery of Mitral Stenosis" and Dr. MacLeod will discuss "Prevention and Treatment of Rheumatic Fever."

Scientific Papers

THE LOWER MIDLINE INCISION

CHARLES B. MAREK, M.D. AND JOSEPH R. DOLCE, M.D.*

Baltimore, Md.

The lower midline incision is perhaps used more frequently by the gynecologist than any other, since it has the widest range of usefulness. Yet, in spite of its universal employment, actually there are relatively few who utilize its advantages at all times and to its fullest extent. Very frequently, although beginning initially as a midline skin incision, the end result terminates in a paramedian incision which splits one or the other rectus muscle. The surgeon who cuts directly through the muscle or separates the fibres deliberately, does so either because he feels there is a lessened hazard of a resulting hernia, or because on failing to find the line of separation when first incising the fascia, he will not trouble to seek for it further. On the other hand, those who do seem to take pains to seek the midline, then proceed to open the peritoneum to one side and enter the abdominal cavity without incising the inter-rectal sheath, exposing the opposite muscle or mobilizing the peritoneum, thus declining to exploit the incision to its fullest extent.

With regard to the fear of a subsequent hernia, we do not think this need be considered, as hernias have occurred about equally after both methods. And we are further of the opinion that there are distinct disadvantages in cutting through the muscle, since not only is there apt to be a great deal of troublesome bleeding from the torn vessels, but also the incision severs the nerves resulting in a weakened muscle. Moreover, the incision cannot be satisfactorily retracted, greater force being necessary to sepa-

rate the muscle in its abnormal line of cleavage, while the complaint of pain in the abdominal wound during the first few days after the operation is more marked. Vertical section through the midline has the advantage of being almost bloodless, cutting no fibres, injuring no nerves, and giving access to both sides of the abdomen.

By referring to any textbook on gynecology, one can readily learn certain fundamental facts relative to the lower midline incision which are both pertinent and highly significant. It should be borne in mind, however, that it is essential for these texts to cover a multitude of subjects, and while the descriptions must of necessity be concise and limited, they are frequently wholly inadequate in their discourse. The surgeon may conceivably also be confused by the descriptions of the rectus sheath in the standard textbooks of anatomy which are singularly alike, being stereotyped and oversimplified. Without exception, it is stated that in the region superior to the level of the linea semicircularis, the internal oblique aponeurosis divides into two lamellae, one blending with the external oblique aponeurosis as it passes in front of the rectus muscle, the other fusing with the aponeurosis of the transversus as it passes behind the muscle; it is further stated that in the territory situated inferior to the level of the semicircularis, the aponeurosis of the three muscles join while coursing across the front of the rectus, leaving the latter's posterior surface in direct contact with the transversalis fascia. The diagrams so illustrated in these books depict this transversalis fascia as continuing from one side across to

* Resident in Surgery, Bon Secours Hospital.

the other without interruption. As a matter of fact, however, each side terminates in the midline where after fusing to form the inter-rectal sheath, the fascia inserts into the linea alba. Yet, in but few articles in the anatomical literature have the conventional statements regarding the constitution of the sheath been either questioned or refuted. Walmsey and Chouke both recognized variations in the constitution of the sheath. Anson and McVay even go so far as to state that the rectus muscle inferior to the linea semicircularis does not lie upon the transversalis fascia proper, but upon a leaf derived from the main layer which splits to invest the muscle and then continues to the linea alba.

To further emphasize the great discrepancy in the description of the rectus sheath, we carefully noted the presence or absence of the pyramidalis muscle in a large number of laparotomies. Chouke claims the pyramidalis was found to be absent in over 22%, while Piersol stated it could not be found in 16%, and Gray mentions merely that it may be absent on one or both sides. However, our experience does not substantiate these findings. Careful observation during over three hundred operations disclosed an absence of the muscle in only 7% of the cases. It would be difficult indeed to explain this wide variance, but the large amount of material may prove to be the important factor, while the sex may also have some bearing on the results. In Chouke's series of 136 cadavers, only 20 were females, while our report is based entirely on female patients.

After reading the average text, one would surmise that it is necessary simply to incise vertically along the linea alba and both recti muscles will fall into view in the lower portion of the incision. But, this is not the case, since it is usually necessary to dissect out the opposite rectus muscle by cutting through the inter-rectal fascial sheath as explained in detail somewhat later. It is also noteworthy that an extensive search of the literature of the past twenty-five years failed to reveal any single article devoted to the midline incision, *per se*, save for those

mentioned previously in textbooks, and since these reports are not too informative, the picture remains somewhat obscure. Primarily, because of the confusion which seems to surround the mechanical features pertaining to the technical aspect of the incision, especially in the minds of the tyro, it will be our purpose to make a conscientious effort to clear up the maze of uncertainty which usually confronts the novice, by presenting the subject in a detailed manner.

The technique finally adopted is a combination and modification of various steps which have been employed by others, no priority being claimed for any step in this procedure. We believe that it is a sound approach which is associated with less trauma and lends itself to adhering to the fundamental precepts and principles inherent in good surgery. It would seem obvious that this technique offers theoretically, at least, definite advantages and it is our opinion that the reward far exceeds the trouble and the few extra minutes spent in dissecting out the various abdominal layers. We have also been particularly mindful of the fact that nature is an excellent healer and that there are many who feel that a meticulous dissection of the abdominal wall is unnecessary. While this may be true in a small measure and while we do not mean to imply that this is the only satisfactory approach, yet there are few who would dispute the statement that wounds heal better when blood and nerve supply is left unimpaired, the tissues untraumatized, with the layers approximated carefully in an anatomical order.

Consideration must also be given to several fundamental factors which will increase the efficacy of the incision allowing the operator to exploit its full length. Preliminary catheterization of the bladder is an absolute requisite, affording greater exposure and precluding the possibility of bladder injury. Operation in the presence of a distended bladder can readily convert a fairly simple procedure into a rather formidable one, so to speak, besides preventing full utilization of the incision, since the peri-

toneal opening must necessarily be limited by the advancement of the bladder superiorly. Secondly, it is the accepted opinion that extension of the incision inferiorly provides twice as much exposure as a corresponding extension superiorly, or to quote the words of a well known surgeon, "an inch below is worth two inches above." Thirdly, the Trendelenberg position allows the intestines to be displaced toward the upper abdomen, drawing them away from the anterior abdominal wall, this being of inestimable value during the operation. The advantage of this is

tissue aside by sharp dissection. The linea alba is incised preferably slightly to the right of the midline, the curved scissors being used to free the rectus fascia from the underlying muscle, the incision then being extended to its full length superiorly and down to the very surface of the pubic bone. By and large, there should be little difficulty in finding the midline for separation of the recti muscles. If the line of demarcation is not apparent, it will be found that the cut edge of the fascia can be separated from the underlying muscle with the dissecting forceps more

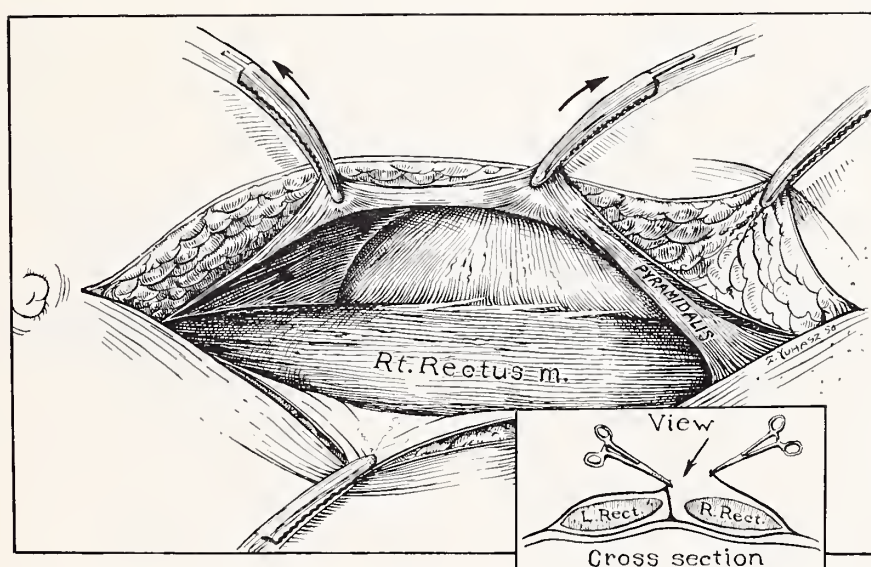


FIG. 1. Schematic drawing depicting the incised rectus sheath with the right rectus and pyramidal muscles exposed. The posterior layer of the rectus sheath is shown inserting medially into the linea alba.

twofold; the danger of intestinal injury in opening the peritoneum is greatly lessened, and packing of the intestines is rendered much less difficult, inasmuch as the intestines tend to fall away from the area as soon as air enters the peritoneal cavity.

The lower midline incision technic extends from a point 1-2 cms. below the umbilicus to the symphysis pubis. The cut is carried down to the fascia which is freed of the adherent fat for a distance of approximately 1 cm. on each side of the linea alba, being most easily accomplished by holding the knife at a slight angle, while with sweeping strokes, one pushes the fatty

easily on one side than on the other, this representing the lateral portion. Likewise, at this point, the pyramidalis muscle in the lower end of the fascial incision is also most useful in directing the surgeon. These arise from the symphysis pubis on a broad base, the outer margin being directed inward and upward, and the two converging into the midline, forming a pyramid. There may be considerable variation in the development of these muscles, some being very prominent and muscular, while others may be somewhat atrophic and fibrous. The medial cut end of the fascia is grasped with two Kelly clamps, placed on tension, and the tendinous

fascicular strands of the inner surface of the rectus muscle which insert into the posterior portion of the linea alba are severed by downward strokes of the knife, held at a slight angle to prevent incision of the fascia.

The muscle can then be separated from the midline with the handle of the scalpel, thus exposing the inter-rectal sheath. This barrier is incised in its lower portion and the incision extended with the curved scissors, being extremely

fascia anteriorly with the handle of the knife, being careful to avoid injury to the perforating branches of the epigastric vessels.

Using the fingers and knife handle for blunt dissection, the left muscle is now separated from the severed inter-rectal sheath, after which, the posterior rectus sheath is freed from the under-surface of the muscles on each side for a distance sufficient to permit the mobilization of this layer and allow its partial delivery to facilitate open-

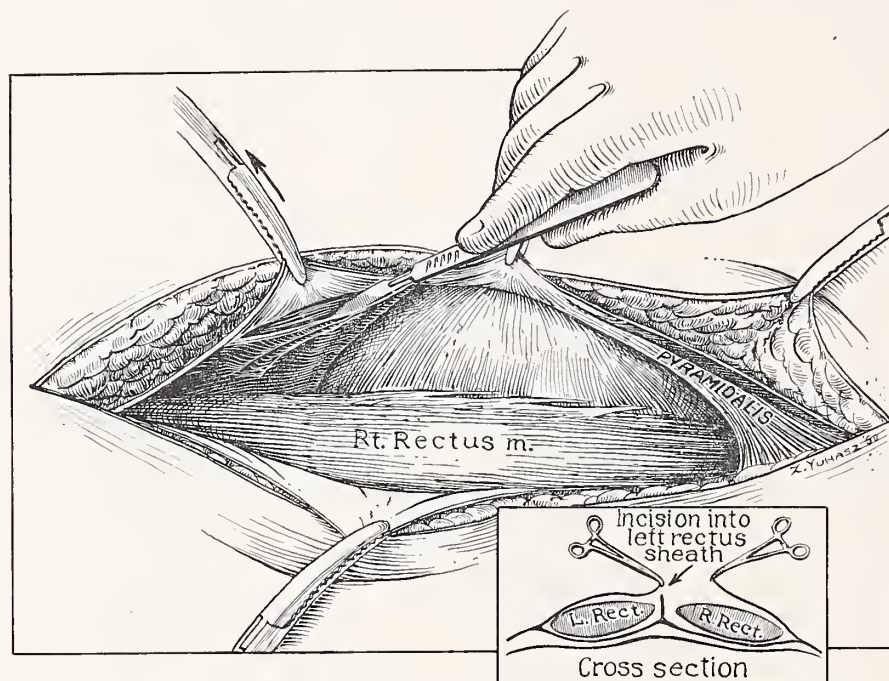


FIG. 2. Schematic drawing showing the incision in the inter-rectal septum opening into the left rectus sheath. The semicircular ligament is shown as the darkened area in the upper third of the incision.

cautious in the superior portion because of the proximity of the peritoneum. At this point, above the semicircular ligament, the inter-rectal sheath is comprised of a substantially thicker, flattened fascial band, so that to all outward appearances, it would seem that the anterior and posterior rectal sheaths had fused along the midline. In this area, also the peritoneum adheres closely to the posterior rectus sheath. At any rate, it is a comparatively simple matter to extricate the opposite rectus muscle, and opening the peritoneum accidentally can easily be averted by exercising the normal amount of care. Both muscles are then partially separated from the

ing and closing of the peritoneum. The transversalis fascia is grasped with mouse tooth forceps, incised longitudinally, thereby exposing the preperitoneal fat. When this is divided, the peritoneum becomes visible, and usually, the urachus can be seen in the midline. This may be a substantial band and easily demonstrable, as is often the case, but occasionally, it is represented by a thin fibrous cord; in any event, the structure is always present and serves as a useful guide in opening the peritoneum. With considerable circumspection, one proceeds to open the peritoneum, this being done in the upper one-third of the incision to avert damag-

ing the bladder, but at the same time, exercising great caution to avoid injuring the bowel.

The peritoneum is stretched between the forceps, slightly raised, and carefully nicked so that air can enter and displace any intestine or omentum that may be lying in close opposition. After the cut edges are grasped with Kelly clamps, the incision is enlarged by inserting the index and middle fingers of the left hand into

on each side, forming a triangle with the apex upward and coursing inferiorly to the inguinal region thence joining the internal iliac vessels in the pelvis. It need hardly be said that there is little excuse for accidental injury to the bladder, since it may be recognized readily by sensual examination; to wit, by the pyramidal appearance of the area at the junction of the urachus with the bladder, by recognizing the fleshy

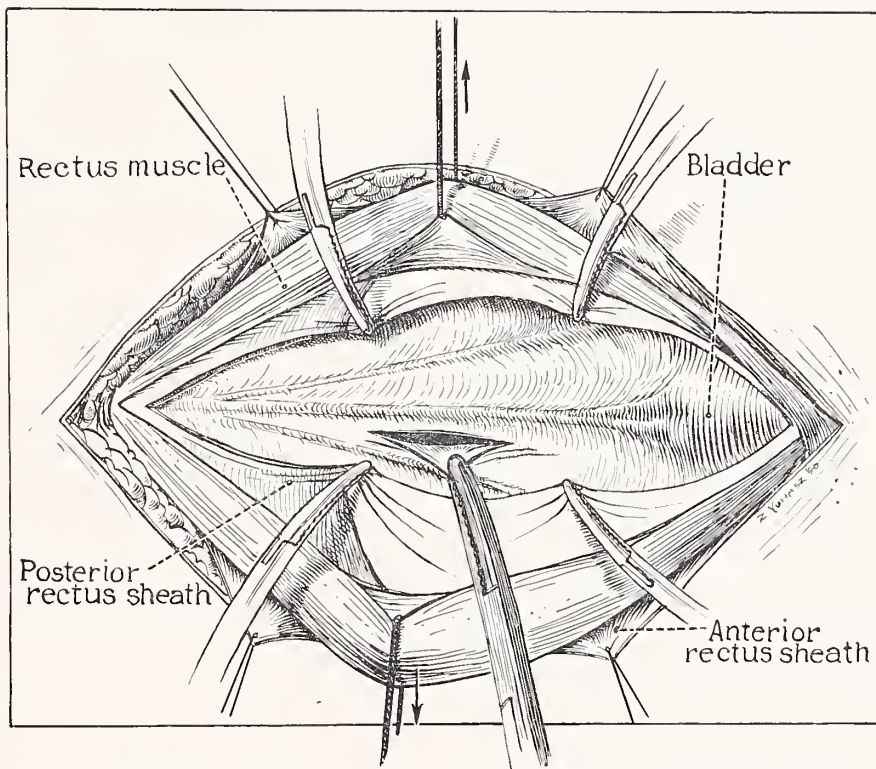


FIG. 3. Schematic drawing disclosing the urachus in the midline fusing with the bladder inferiorly; the obliterated hypogastric arteries are seen on each side of the urachus. The posterior rectus sheath is held laterally with clamps.

the peritoneal cavity, palmer surface upward and with a lifting motion, the peritoneum is divided between the two fingers slightly to one side of the urachus down to the very edge of the bladder. The same fingers of the right hand are used to elevate the peritoneum while extending the incision superiorly with the knife in the left hand. One should not confuse the urachus with the obliterated hypogastric arteries which in the upper portion of the incision are close to the midline. In the main, the latter are smaller in size and diverge laterally from the umbilicus

pink appearance of the muscular fibres of the organ, and by direct visualization facilitated by holding up the peritoneum and looking at it through its inner surface when the limitation of its transparency will indicate the position of the bladder.

Closure of the peritoneum should begin invariably at the superior portion of the wound, since in this area the layers are compact, rather rigid and fixed and difficult to mobilize, while the intestines lie in close proximity, forever presenting a real source of danger. Generally

speaking, it is considered more prudent, therefore, to place the initial suture, under guidance of the fingers, with adequate visualization afforded by the open incision. The continuous stitch should evert the peritoneal edges to render a smooth intra-abdominal suture line, while whenever feasible, the cut edges of the transversalis fascia should be included in the suture. On approaching the inferior portion of the incision, it will be noted that the peritoneum can be lifted easily for a considerable distance through the incision. Furthermore, in this area, the intestine is rarely in close contact since the pelvis is proportionately deeper than the upper abdomen and the intestines fall away from the peritoneum, so one is able to complete the suturing relatively free from apprehension. It is our custom always to approximate the recti muscles with a continuous interlocking suture of plain zero catgut. While there might be some controversy over its necessity, few would persist in the claim, that it does any harm, while in many cases, it perhaps does some good. We feel that it is an added safeguard which may prove beneficial and invaluable in furnishing additional support. The remaining layers of the abdomen are approximated in the usual manner, interrupted figure of eight chromic zero catgut sutures being utilized in the deep fascia, double zero plain in the fat and superficial fascia, while interrupted black silk sutures are used to close the skin. Retention sutures are employed only rarely in extremely fat individuals, since it is our opinion that they serve no useful purpose

except perhaps to prevent disruption of the skin in infected wounds.

CONCLUSIONS

1. While the lower midline incision is employed extensively by gynecologists, few utilize its full advantages.

2. It is less traumatic, being associated with less bleeding and spares injury to the nerves.

3. Misconception, arising from the equivocal description of the rectus sheath by the standard texts, probably accounts for the existing confusion and the reluctance on the part of some operators, especially the neophyte, to seek the exact midline.

4. An attempt is made to present the opening of the abdomen in a detailed, sequential and anatomical order, with special emphasis on the structure of the rectus sheath and landmarks in finding the midline.

5. Although we should not like to leave the impression that this constitutes the only satisfactory approach to the pelvis, it is our sincere feeling that the method described is superior to the others.

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THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and
 the Medical and Chirurgical Faculty

Richard W. Telinde, M.D., *Chairman*

Beverley C. Compton, M.D., *Secretary*

Thursday, October 16, 1952

5:00 to 6:00 p.m.

Reports

COMMITTEE ON RURAL MEDICINE

MEDICAL STUDENT PRECEPTORSHIP

The Committee on Rural Medicine has been studying the problem of placing medical students who have finished their junior year with some rural physician on a preceptorship basis. It is understood that some type of recompense be worked out between the student and the physician.

The legal problems have been ironed out and the physician may use this man under his supervision, or under direct supervision of a licensed physician in case of his absence. Before contacting the members of the present junior class, the Committee on Rural Medicine would like to know how many rural physicians would be interested in having a student during the summer months on a preceptorship basis. The letters must be in before November 1, 1952, and should be addressed to Dr. Page C. Jett, Chairman, Committee on Rural Medicine, Prince Frederick, Maryland.

★ ★ ★ ★ ★

ARE YOU INTERESTED?

Veteran-Physicians of World War II

Dr. William T. Spence, Secretary-Treasurer of the Physician-Veterans Society, 1150 Connecticut Avenue, Washington 6, D. C., states that after a survey it was found that 25% of the States would like to have a national Veteran-Physicians Organization.

If you, as a Veteran Physician, are interested in the formation of such an organization, will you indicate your wishes to the Faculty Office, 1211 Cathedral Street, Baltimore 1, Maryland?

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SOCIALISM IS ON THE MOVE

ROBERT W. GARIS, M.D.*

In the concluding remarks of his presidential inaugural address to the American Medical Association on June 10, 1952, Dr. Louis H. Bauer stated "I am proud to be a member of the American Medical Association which has spear-headed the fight against the Socialism that is creeping over this country." That our Governmental course has been proceeding steadily toward State Socialism in recent years is beyond

the shadow of argument. Whether we call the present trend Collectivism, Statism, Welfare State, or "Ruinism," as Senator Harry F. Byrd terms it, these new policies of Government, unless quickly checked, will destroy the American system of competitive free enterprise together with our even more important individual freedom and liberty.

The Socialist Party has not campaigned actively in a Presidential election since 1932, and yet today, virtually every plank in that 1932

* Member, Committee on Public Medical Education, Baltimore City Medical Society.

socialistic platform has been enacted into Federal law, and in some cases enlarged upon. Deficit financing, price controls, Governmental housing, Federal water and electric power projects, "full employment" laws, and Federal Aid to education are but a few of the socializing items adopted by the Federal Government—22 such items were recently listed by Earl Browder, former leader of the Communist Party and an authority on Communism and Socialism. Among current socializing projects, as yet lacking enactment into law, are socialized or state medicine, the Brannan Plan—which inevitably means socialized agriculture, and another large extension of socialized housing. These three proposals alone would mean socialization of our health, our food, and the roofs over our heads. Space does not permit citing many other trends to Socialism, such as the constant advocacy by the Truman Administration of an extension of the number of those receiving payments from the Treasury of the United States—already 17 million Americans receive regular payments directly from the Federal Government and 8 million more are on the rolls of Counties, Cities and States. A population of government dependents is a socialized population.

Not so well known are two recent Government projects of socialistic nature, which have come to the attention of the Committee of Public Medical Education of the Baltimore City Medical Society. I wish to briefly detail these two proposals.

The first deals with the Niagara Power project. A guest editorial by Dr. John F. Kelley in the *Bulletin of the Utica Academy of Medicine* summarizes the Niagara question. A 1950 treaty with Canada opened the door for the development of vast new resources of electrical energy at Niagara Falls without interfering with its scenic beauty. Three bills authorizing the project are now before Congress. The private enterprise Capehart-Miller bill would permit the five New York State electric companies to do the job collectively. The other two bills, by Lehman-

Roosevelt and Ives-Cole, call for government development and ownership. Never in the last twenty years of encroachment by government on the free initiative of the American people has so clear an issue been presented between government ownership and private enterprise as is embodied in the three proposals to develop additional power from the Niagara River. The Niagara issue is solely one of development of electric power. It does not involve navigation, reclamation, flood control, irrigation, sanitation, or any of the guises previously relied upon by government to go into the electric business. The Niagara project has no connection whatsoever with the controversial St. Lawrence Seaway and power project, which is geographically 250 miles from Niagara Falls.

This clearly defined issue between governmental ownership in direct competition with private enterprise is basic and fundamental, not only to the entire structure of American economy but also to the structure of the private life of individual Americans—and this particularly includes doctors, dentists and nurses because of their deep interest in any matter involving socialization of segments of American life. If government ownership should win out, then a principle or precedent will have been established giving tremendous leverage to future arguments for government ownership. This means another cog in the process of socialization and an alarming outlook for private enterprise.

By letting our representatives in Washington know we favor the private enterprise (Capehart-Miller) bill, we can help check further inroads of socialistic scheming and aid in preserving our American way of life. I may say that our Committee of Public Medical Education by unanimous vote instructed our chairman, Dr. Amos R. Koontz, to write to all Maryland Congressmen urging their support of the Capehart-Miller bill and their opposition to the Lehman-Roosevelt and Ives-Cole bills.

The second piece of proposed legislation upon which our Committee has recently taken action

concerns the expenditure of Federal funds for aid to education. The Indianapolis Medical Society at a meeting on March 4th and speaking for more than 900 members, went on record as being opposed to any such legislation; and initiated a movement to bring its stand to the attention of all of the units of the Parent-Teachers Association in Marion County, Indiana. A letter was sent to each Parent-Teachers Association president stating in a most friendly manner the reasons for the Medical Society's position on this matter. It was brought out that its opposition to Federal Aid to Public Education was "consistent with its opposition to other Federal control problems, which can well mean eventual socialization of industry, business, and other free institutions." The letter continues as follows: "By no means does it mean that the Medical Society is "against" education per se but it does mean that we believe our schools can best be operated at the local and state level without direction from a bureau in Washington."

"The long record of the medical profession in its campaign for better school health programs, its advocacy of more hospital facilities and its interest in steadily making inroads on the diseases of children" tends to point up the interest of the profession in schools and related problems. However, the advances which have been made have been brought about by cooperative action in our state and in our own local communities without benefit of federal hand-outs or direction as to how those hand-outs should be spent."

"We believe, along with other responsible groups and individuals, that federal aid to education will, in the end, mean federal control of the public schools of this country. History has proved that no federal bureau can long resist the temptation to take full advantage of "purse string" opportunities to enlarge its own power and to impose its own thinking and its own inept management upon the state and local government service for which it provides part or all of the finances.

"Why should the doctors take a stand in this

issue? We do not see how we can fight efforts to socialize the medical profession and, at the same time, blink at the same effort to socialize the free schools of the nation. Both are part and parcel of the same big effort—to direct this country down the painful road of state control, a route which has been so disastrous for so many nations which mistakenly believed they 'were getting something for nothing.' "

"We are joined, incidentally, in our thinking by such men as General Dwight D. Eisenhower, Senator Harry F. Byrd, Dr. Herman B. Wells of Indiana University, Dr. Frank H. Sparks of Wabash College, and many others."

In view of the information that the National Parent-Teachers Association organization was on record as favoring Federal aid to education and was holding its national convention in May in Indianapolis, the Indianapolis Medical Society also contacted other state and County Medical Societies, citing its stand and the reasons therefore, with the hope that similar action might be initiated throughout the country with a view to reversing the present stand of the National Parent-Teachers Association organization.

This matter was brought before the Committee on Public Medical Education of the Baltimore City Medical Society. The Committee by unanimous vote went on record as being opposed to any legislation which would approve the expenditure of federal funds for aid to education, and a letter similar to the above was mailed to the president of each P.T.A. group in the state of Maryland.

The two governmental proposals detailed above, serve but to emphasize the continuing attempts of the present administration to lead this country down the road to complete state socialism with its government subsidies, controls, regimentation, doles, and eventual elimination of individual enterprise and initiative.

"The American system has developed individual freedoms under constitutional democracy to the fullest measure ever known to man. It is the system which is always ready to supply the vital

spark needed by the deserving to expand mediocrity into genius. It is the system which supplies the incentive to every American to start at the bottom and rise to the top. It is the system which enables us with only six per cent of the world population to out-produce the rest of the world combined." So states Senator Byrd in his recent address at Los Angeles to the American Medical Association. Can Socialism or Communism equal this? The answer is clear.

In concluding, may I again quote from the inaugural address of Dr. Bauer. "This is the

year in which we must decide whether we want this country to continue its majestic growth as the greatest Nation of free men the world has ever seen, or fall into lockstep with the decadent Socialisms and Totalitarianisms of the old world. This is the year in which we must live up fully to the proud privilege and responsibilities of citizenship which generations of Americans have worked, fought and died to hand down to us. This is the year in which we must rededicate ourselves to the full execution of our right of franchise." Can we as American citizens do less?

MEN OR MICE IN NOVEMBER?

AMOS R. KOONTZ, M.D.*

For years doctors have been bemoaning their own lot and bemoaning the fate of their country. Most of this has been done in hospital corridors, doctors' coatrooms, and around hospital luncheon tables. The creeping blight of socialism is acknowledged and felt by all. What have most doctors done to halt its progress or to stop it? A great many (and some of our leading ones too) are so puerile and paltry as to say "We can't do anything about it, so we might as well accept it." There were probably also such men in 1776. Undoubtedly they left a vast progeny. They had time for procreation while their neighbors who believed in freedom were fighting their battles for them.

In Argentina recently all doctors were required to sign a statement of their political faith. If they stated that they believed in the wrong things, they lost their hospital appointments. Self-seekers who are planning the socialization of our profession, as well as that of all other phases of our national life, will, if they succeed, have us in the situation in which they can do the same thing for us.

* Chairman, Committee on Public Medical Education, Baltimore City Medical Society.

The big question now is whether we are going to take it lying down, or stand up and fight like men? Are we going to be men or mice in November? Those who are going to be mice may not even take the trouble to go to the polls to vote. They may spend the day playing golf or going hunting. The *men* will vote. Also they will see that the members of their families vote. Also they will remind their neighbors to vote.

I strongly urge that all doctors in Maryland do better than that. Maryland has a great medical heritage as well as a heritage of great patriotism. It is our duty then to see that the same thing does not happen in 1952 that happened in 1948—namely that only 50% of the people of the country voted in the Presidential election. Will you not join with us in agreeing to make no appointments in your office or elsewhere on election day, and in agreeing to see only emergency cases on that day?

We further suggest that doctors, the ladies auxiliary, and other allied organizations form groups and arrange to telephone everyone in their communities to ask them to go to the polls and vote. We cannot all believe in the same thing or the same candidates, but we can show enough

interest in the preservation of our American ideals to vote against the people whom we think are trying to destroy them. Groups should be organized to take people to the polls who have no way to go. If women with children need baby sitters, why could not doctors' offices serve as

community baby sitting establishments? It is up to us. The time for mere talk is over. The time for action is here. It cannot be that there are many mice among the doctors in Maryland, but remember—you might as well be one as to act like one.

COMPARISON OF THE REPUBLICAN AND DEMOCRATIC PARTY PLATFORMS

It is interesting to note that this year's statement of policy on the health issue by the Democratic National Convention is considerably more moderate than the position taken by President Truman, and is also more moderate than the Party's previous position.

The Democratic Health Plank, while it advocates Federal aid to medical education, does not contain specific endorsement of National Compulsory Health Insurance.

As anticipated by medical leaders, when the President's Commission on the Health Needs of the Nation was created some six months ago, the Democratic statement of policy seeks to avert a showdown before the voters on the health issue by commending President Truman for the creation of a "non-partisan Commission to seek an acceptable solution of this urgent problem."

The Republican statement of policy on the health issue this year, as you will recall, was an unqualified declaration that "We are opposed to Federal Compulsory Health Insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight and debased standards of medical care." The Democratic plank is anemic by comparison.

HEALTH INSURANCE PLANK 1952 DEMOCRATIC PARTY PLATFORM

Medical Education: We advocate federal aid for medical education to help overcome the growing shortages of doctors, nurses, and other trained health personnel.

Cost of Medical Care: We also advocate a resolute attack on the heavy financial hazard of serious illness. We recognize that the costs of modern medical care have grown to be prohibitive for many millions of people. We commend President Truman for establishing the non-partisan commission on the health needs of the nation to seek an acceptable solution of this urgent problem.

HEALTH INSURANCE PLANK REPUBLICAN PARTY PLATFORM

We recognize that the health of our people as well as their proper medical care cannot be maintained if subject to federal bureaucratic dictation. There should be a just division of responsibility between government, the physician, the voluntary hospital, and voluntary health insurance. *We are opposed to federal compulsory health insurance with its crushing cost, wasteful inefficiency, bureaucratic dead weight, and debased standards of medical care.* We shall support those health activities by government which stimulate the development of adequate hospital services without federal interference in local administration. We favor support of scientific research. We pledge our continuous encouragement of improved methods of assuring health protection.

Component Medical Societies

ALLEGANY-GARRETT COUNTY

LESLIE E. DAUGHERTY, M.D., *Journal Representative*

The following article appeared in the Cumberland Evening Times:

Allegany County's medical profession is well on its way to providing assistance in event of direct attack or as a casualty clearing station for victims from metropolitan centers.

This is indicated in a report made recently to a meeting of the Allegany-Garrett County Medical Society and joint staffs of Sacred Heart and Memorial Hospitals by Dr. Leslie E. Daugherty, medical director of Civil Defense in the county.

Dr. Daugherty said while it is believed by all strategists the county will not be a target for direct attack, it is likely "we will be overrun by displaced persons from other areas such as Pittsburgh, Washington and Baltimore."

It was his opinion that adequate medical defense cannot be provided unless the assumption is made that atomic destruction is a possibility. Since one hit would almost certainly cripple transportation, demolition bombs are considered a much greater possibility, he stated.

"In any eventuality or threat, Allegany County becomes a target either by direct hit or being overrun by displaced persons," Dr. Daugherty said.

Dr. Daugherty said Cumberland has a population of approximately 40,000 and the smallest unit for defense is based on 10,000 which can be cared for by one casualty clearing station.

A station normally replaces existing organized facilities of an established hospital, he said, adding that there are two hospitals here, one in Frostburg and another in Westernport.

The county has been designated as a six casualty clearing station area. Under this Cumberland will have four, Frostburg and Westernport one each.

"Cumberland already has two well organized casualty clearing stations. One is near Memorial Hospital and one in the South-End, where, most likely, facilities will be needed in case of being overrun from the Baltimore area. Many first aid

stations will be set up throughout the whole area, to prevent the organized hospitals from being overrun by minor injuries and illnesses. Illness from epidemics due to disturbed water supplies and heating facilities and food distribution, will far outnumber direct injuries and every person must be made conscious of his responsibility and must be trained in first aid," Dr. Daugherty said.

"Parent teacher associations will be asked to supply all lay personnel, so that Red Cross nurse's training schools, hospital staffs and already trained first aid workers can train these people to not only assist themselves, but aid others in any emergency.

"Any other emergency can be a factory explosion, railroad train wreck, or fire in downtown Cumberland, at any time and does not need to be a major war or threat of war.

"So, it is incumbent on we as physicians and nurses, to see that Allegany citizens are adequately prepared to meet any emergency, or any great disaster," the director asserted, adding:

"Cumberland will have four great hospitals. An 800-bed hospital located in Fort Hill High School building and a 600-bed hospital located in Gephart School, Frederick Street. The capacities of Sacred Heart and Memorial Hospitals will be doubled. To do this, necessary personnel and medical and surgical staffs must be retained by the two hospitals and the rest released for the auxiliary hospitals.

"Equipment and supplies, medicines and instruments are already in Cumberland, or are on the way to equip these auxiliary hospitals and casualty clearing stations.

"Existing hospitals will be asked to carry on hand twice the amount of supplies at all times. Drugs will be kept fresh on a rotation basis. The local hospitals will be designated "Storing facilities" and supplies to be drawn upon by the casualty clearing stations," Dr. Daugherty stated.

The director said medical services, under the title "medical personnel" is made up of five categories: Physicians, nurses, dentists, pharmacists and auxiliary workers. These will be responsible

for procurement, training and assignment of personnel.

Daugherty said it is time for the two hospitals here to screen their staffs and assign auxiliary hospitals a complete and competent working force which could be activated immediately.

BALTIMORE CITY MEDICAL SOCIETY

PATHOLOGICAL SECTION

WILLIAM V. LOVITT, JR., M.D., *Secretary*

The May meeting of the Pathology Section of the Baltimore City Medical Society was held in conjunction with the Maryland Society of Pathologists, Inc. at the National Institute of Health, Bethesda, Maryland. Dr. Harold Stewart and his associates at the National Cancer Institute were hosts for the meeting and presented a very interesting scientific program. Summaries of the papers are as follows:

- (1) A Case of Human Rabies Resulting from the Bite of A Rabid Fox, JAMES H. PEERS, M.D., National Institutes of Health, Bethesda, Md.

The subject of this report was a 32 year old woman resident of Dallas, Pa., a small town in the mountains above Wilkes Barre. Rabies was reported to be epidemic in the foxes of the area. The patient was attacked in her own yard by a fox which bit her in the left index finger through a glove. She strangled the fox, and the head, sent to the State Laboratory in Harrisburg, was reported positive for rabies. At the local hospital the finger was soaked in saline and peroxide and she was given penicillin and tetanus antitoxin. Two days later treatment with phenolized rabies vaccine was begun. After the eighth daily dose she began to complain of headache and pains in the knees and was admitted to the hospital. Because of fear of post vaccinal reaction, on advice of both the local consultants and the Medical Director of the firm manufacturing the vaccine, subsequent doses of the vaccine were administered in very dilute form and thereafter, she never received more than $\frac{1}{20}$ of the customary dosage, and mostly much less. For the following 11 days she presented at various times some symptoms of an allergic reaction to vaccine consisting of headache, joint pains and general malaise. During the

night of the 20th day after being bitten she rather suddenly began to have swallowing difficulty, agitation and disorientation quite suggestive of furious rabies, but the consensus of medical opinion was that this was a hysterical reaction. However, her condition rapidly worsened; she became violently maniacal and then semicomatose and died in the early hours of the morning of the 21st day after being bitten.

Complete post mortem examination of the arterially embalmed body showed no significant gross abnormalities, but it was noted even then that the facies presented a notably "wild" expression. Extensive histopathologic examination of the brain showed only scanty lymphocytic infiltration about a few vessels in the midbrain and medulla. A number of cells in the substantia nigra and a few in the medulla showed various degenerative changes up to actual necrosis with little or no cellular reaction. In the cerebellum a number of the Purkinje cells, possible 1% of the total, contained 1 to 6 small Negri bodies, but showed otherwise little or no degenerative change. A few Negri bodies were also seen in the large cells of the hippocampal gyrus, tegmentum of the midbrain and reticular substance of the medulla. No perivenous microglial reaction in the white matter, characteristic of post vaccinal encephalitis, was present.

The case was thus one of furious rabies, not retarded by incomplete treatment and running the unusually short course of 21 days.

- (2) Benign and Malignant Chordomas: A Clinico-anatomical Study of 22 Cases. CHARLES C. CONGDON.

Twenty-two cases of chordoma were reported. Four were benign and 18 malignant. The benign chordomas were incidental autopsy findings in three cases. The fourth case was found in a surgical specimen of the coccyx. None of them produced symptoms. The coccygeal case showed probable origin of the tumor from an intercoccygeal disk. Eight of the malignant chordomas were situated either in the cervical spine or on Blumenbach's clivus. Ten of the malignant chordomas were situated in lumbar vertebrae or in sacral and coccygeal segments. One of the lumbar chordomas at the time of operation was seen to arise from an intervertebral disk. The variations in the microscopic structure of chordomas

were illustrated and the problem of histogenesis discussed.

(3) Cancer in Domestic and Wild Animals. W. H.

EYESTONE

A discussion of the comparative features of incidence and morphologic types of tumors in domestic and wild animals. In animals, as in man, tumors of the mesoderm are more common in younger age groups while ectodermal tumors tend to appear more frequently in the declining years. Some morphologic types of tumors, which are rare in man, such as mesotheliomas are seen with relative frequency in cattle. The mode of origin of certain tumors, such as seminoma of the testis in dogs and melanoma in the sheep, more clearly demonstrate the cells of their origin than comparable tumors in man. Certain tumors of animals, such as the mast cell tumors in dogs, have not been reported in man. A study of the various species of animals autopsied in Zoological Parks indicates that the overall incidence of cancer in these captive wild animals is similar to that in man, but that in primates, it is probably lower than in man.

BALTIMORE COUNTY MEDICAL SOCIETY

DONALD L. SOMERVILLE, M.D., *Journal Representative*

The Maryland Institute of Art was the scene of the June luncheon meeting of the Baltimore County Medical Association, which was held on June 18, 1952. This was indeed, a memorable, enjoyable and extremely interesting meeting insofar as this was the first time a medical meeting was held within such an artistic domain.

Luncheon was served in the Main Hall with the participants surrounded by beautiful paintings, drawings, statues, and figurines.

This was a joint meeting with the Woman's Auxiliary of the medical society. The Woman's Auxiliary granted a scholarship in nursing to Miss Carol Ann Wienefeld of Freeland, Maryland. She will have the opportunity of selecting her own school of nursing and the Woman's Auxiliary will handle all financial arrangements for the usual 3-year course.

The Committee on Public Relations gave the prizes to the winners of the recent art contest. Lee Einwaechter of Arbutus received a \$50.00 Defense

Bond for first prize, Margaret Grimm of Pikesville was given a red ribbon for second prize, and to Tom Riley of Towson, went a white ribbon for third prize.

The Society extended special thanks to Miss Margaret Glace, Dean of the Institute, who arranged this wonderful meeting, and to Miss Olive Jobes, Supervisor of Art in the Secondary Schools of Baltimore County who has so much to do in arranging the exhibits. Others who received commendation were Mrs. Florence Zavadil of Baltimore city who helped the physicians supervise the contest, and Mr. James B. O'Toole, Superintendent of Secondary Education in Baltimore County, with whose cooperation the contest was held.

Dr. Louis Krause of the University of Maryland School of Medicine gave a wonderful talk on "Life in Biblical Times." Dr. Krause has spent many summers in the Middle and Near East and he was able to discuss this interesting topic from personal experience.

A discussion regarding what solution might be reached in the Medical Care problem followed; Dr. J. E. Bradley, of the Council on Medical Care of the Medical-Chirurgical Faculty, spoke of various objections to the problem that have been raised in the past, and gave his council's answers to these objections. It was pointed out that with the cut in funds which the program faces for the coming year, it will be impossible to carry on this work as in the past, for the simple reason that the funds will be gone by March, 1953. Dr. Melvin Davis, of the Sherbow Commission, suggested that the Association devote an entire meeting to discussing the situation so that concrete suggestions representative of the Association as a whole might be sent to the Medical-Chirurgical Faculty, to be used in the form of an appeal to the State Legislature.

ST. MARY'S COUNTY MEDICAL SOCIETY

J. ROY GUYTHER, M.D., *Journal Representative*

The monthly meeting of the St. Mary's County Medical Society was held at St. Mary's Hospital. A motion picture was shown on "Cancer of the Uterus—The Problem of Early Diagnosis." The doctors of the staff pledged their support of the hospital expansion program that is currently under way.

Representatives of the Charles, Calvert and St. Mary's County Medical Societies met at Hughesville on June 19th to discuss the Medical Care Program. The meeting was conducted by Dr. Page Jett

of Prince Frederick, who outlined the problems confronting the Medical Care Program and asked for suggestions and opinions of the group to remedy the problems.

* * * * *

SYMPOSIUM ON TRAUMA AND ITS RELATION TO DISEASE*

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, October 24, 1952, 8:00 p.m.

PANEL DISCUSSION

Paul F. Due, Esquire, *Moderator*

1. Introduction:

Paul F. Due, Esquire, President of the Bar Association of Baltimore City.

2. Panel Participants:

Honorable Emory H. Niles, Supreme Bench of Baltimore City.

Russell S. Fisher, M.D., Chief Medical Examiner.

Joseph L. Lilienthal, Jr., M.D., The Johns Hopkins Hospital.

Eugene Meyer, III, M.D., The Johns Hopkins Hospital.

(Subjects to be announced.)

3. Question Period. Questions from the floor are invited.

4. Adjournment.

* Arranged by the Joint Committee on Medicolegal Problems of the Baltimore and Maryland Bar Associations and the Medical and Chirurgical Faculty, under the auspices of the Symposia Management Subcommittee which is composed of the following members: Mr. S. C. Berenholtz; Mr. W. L. Galvin; Mr. A. Sodaro; Mr. T. C. Waters; Dr. I. R. Trimble; Dr. R. C. Tilghman; Dr. R. S. Fisher and Dr. L. M. Krause.

* * * * *

THINK OF THIS!

Quacks are the greatest liars in the world—except their patients.

Benjamin Franklin

Contributed by D. L. R.

"Get-Out-The-Vote"

Library

THE CHARLES FRICK READING ROOM AND THE WILLIAM F. FRICK ENDOWMENT FUND

At the inauguration of the Dr. Charles Frick Library of the Medical and Chirurgical Faculty of Maryland, Dr. Samuel C. Chew, in his commemorative address, said, "Do we not well then to keep alive that memory of one so dear to some of us, so honored by all, and to re-consecrate it to-night by associating it forever with books. . . ."

Dr. Charles Frick was born in Baltimore on the eighth of August, 1823, and his death on the twenty-fifth of March, 1860, was the result of contracting diphtheria from a patient. In his short but active thirty-seven years, his accomplishments were many.

Before entering upon his medical career, he was employed as an Assistant Civil Engineer for the Baltimore & Ohio Railroad Company. However, he soon began his chosen profession, when he became a student of Dr. T. H. Buckler and completed his work at the University of Maryland in 1845. Each year his ability as a skilled physician and scholar became evident. He served as a resident at the Almshouse, a Vaccine Physician and a physician to the Maryland Penitentiary and to the Union Protestant Infirmary. He was a founder of the Maryland Medical Institute, which was designed to be a preparatory and supplementary school to medicine, in 1847, and founded the Baltimore Pathological Society in 1853. From 1856 to 1858, he was the Professor of Materia Medica at the Maryland College of Pharmacy until his appointment as Professor of Materia Medica at the University of Maryland. He held this post until his death in 1860.

Dr. Frick left many contributions to medical literature in his few years of strenuous and faithful work. His work is characterized by accurate and careful observation, by patient and laborious analysis and by familiarity with what others had done on the same lines of investigation.

In the early period of his medical studies he wrote his inaugural thesis on the subject of puerperal fever. His other contributions to medical literature were in

the fields of pathology, animal chemistry, analysis of the blood in health and disease and renal pathology. The result of Dr. Frick's labors in the field of renal pathology was the publication in 1850 of *Renal Affections: Their Diagnosis and Pathology*.

In 1896, Dr. William Osler, President of the Faculty, was asked by Messrs. William F. and Frank Frick, brothers of the late Dr. Charles Frick, to lay the following proposal before the Medical and Chirurgical Faculty of Maryland:

- (1) The Messrs. Frick will give \$1,000 to be spent in the purchase of books for a library.
- (2) They desire that such a library shall form part of the library of the Medical and Chirurgical Faculty.
- (3) The works purchased shall relate to the subjects in which the late Dr. Charles Frick was especially interested, namely, diseases of the urinary organs, of the cardio-vascular system, and fevers, particularly the malarial fevers.
- (4) They agree to give during their lifetime one hundred dollars a year to be used in the purchase of new books in connection with the Frick Memorial Library.
- (5) They request that, if possible, a special room shall be set aside for this, in which also they can place a tablet indicating the nature of the Library, and probably also a portrait of Dr. Frick.

The Faculty accepted the proposal made by the Fricks and also the wish of Mr. Reverdy Johnson, a personal friend of Dr. Frick, to contribute the sum of \$100 a year for the purchase of books for the foundation.

For many years the fund was made possible by the donations of the children of the late Messrs. Frick, Mrs. Henry Barton Jacobs and the Messrs. Frick.

In the year of 1927, the Faculty received the sum

of \$20,000 from the estate of Mr. J. Swan Frick. This was to be known as the William F. Frick Endowment Fund and was to be used for the purchase of books and the care of the Frick Reading Room,

which is now located in the present building of the Faculty.

The Faculty bookplate is used and the Frick Fund is so designated.

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"De-VOTE A Day to Democracy. VOTE November 4th!"

Health Departments

SOME OBSERVATIONS OF THE BRITISH SYSTEM OF CARING FOR THE AGED AND CHRONICALLY ILL

The aged and chronically ill person has been acknowledged by medical and lay people alike as the most important public health problem facing us today.

Great Britain, which began its effort toward meeting the problem earlier than we, has gained many insights which may be valuable to Maryland as our chronic disease hospital program proceeds.

In Britain, for example, the medical opinion that, given the right treatment, large numbers of old people who previously were counted as chronically ill and allowed to remain in bed until they died, can be so improved by modern methods of care that they are able to regain some degree of activity, has been confirmed.

Quite naturally a fairly large percentage of patients admitted to chronic hospitals remain indefinitely because of their disabling conditions, but this is not the whole story by any manner of means.

The excellent rehabilitative work being done at Cowley Road Hospital Geriatric Unit, in Oxford, (an integral part of teaching hospital association of Oxford University) through physical and occupational therapy, to point up one shining example, seemed of great significance to me.

The effect of rehabilitative efforts on many long-stay patients was most impressive, the improvement in their physical condition being matched by improvement in their mental state.

At Cowley Road I saw a man of eighty-five who had been a carpenter before admission, doing an excellent job of weaving. Rug making, lamp shade making, leather work and the like, are occupations in which age does not seem to be an obstacle to learning. The Red Cross, in a service called "The Helping Hand" provides an outlet for the sale of articles made by patients, supplying them with materials whose cost is later deducted from the sale of the handiwork with proceeds going directly to the craft-worker.

The Frail Ambulant

The "frail" ambulant offers a challenge to us, which if satisfactorily solved, will do much to keep state institutions from being cluttered with patients who would do equally well in less expensively-operated institutions or annexes with overseer care, and thereby leave hospital beds and facilities for those who require medical and nursing care of a high order.

These patients make up a very large group whose disability is often more one of age than of any particular disease. They are not ill enough to need permanent confinement to bed or well enough, in the absence of good family surroundings, to live normally at home. They often have quite long periods of relatively good health alternating with periods when they need medical care and attention.

The frail ambulant is the kind of patient that the family should be encouraged to care for until medical attention is required. At such times hospital space should be readily available.

Cowley Road Hospital operates on that basis. One example of case handling that impressed me was that of a mother who had been at the hospital. She showed great improvement and her daughter took her home on the understanding that the hospital would be available when the mother needed care that the daughter could not provide. The time came when the daughter wanted a vacation and requested the hospital to keep the mother for this period. Hospital space was found for her and care cheerfully provided.

Such two-way traffic between the chronic hospital and the home must be free of obstacles. Ideally the interchange should provide a fairly comfortable existence for the elderly. The occasional hospital experience will enable the patient to obtain the benefits of any advances in therapy, whether curative or palliative.

The Rehabilitation Program

As in Maryland institutions, in England, emphasis is placed on the importance of a thorough physical examination of all patients. On many occasions

it is found that older patients are suffering from acute diseases which call for the full use of facilities offered by a general, rather than a chronic disease hospital. The English system has established a close integration between the acute and chronic hospitals.

A complete cure is not always possible for the patient who needs general hospital care, but by careful treatment, many effect a considerable restoration toward ambulant existence. In the treatment of such patients, the aim is toward maintenance of function for as long as possible.

The British have found that many patients suffering from hemiplegia as a result of a stroke, can be taught to walk, clothe and feed themselves through a combination of treatment and physical therapy. In England, as here, even a fractured femur, whatever the age of the patient, need no longer be the prelude to a life of useless activity. These are only two of the many conditions that I observed being improved by careful and painstaking treatment.

Here in Maryland, as in England, once it has become possible to establish a turnover in a unit treating elderly chronics, the average length of stay that patients will remain in general hospital wards should fall rapidly and considerably.

Classification of Patients

In general, the English classify their patients somewhat differently from the classifications to which we are accustomed. Because the problem of rehabilitating the elderly is so much greater than that of the young, they separate older patients from the middle-aged and younger patients, largely for organizational rather than clinical reasons. At Cowley Road Hospital in 1951 only 13 per cent of the admissions were under 60 years of age. In the Northeast Metropolitan Region in 1949, an analysis of the 3000-odd chronic sick beds showed that 90 per cent were over 60 while the remaining 10 per cent were under that age.

Younger patients, specifically children with damaged heart or nephrosis, the infant with club feet, are handled at Wingfield-Morris Orthopaedic Hospital with middle-aged patients who have rheumatoid arthritis, ankylosing spondylitis and neuromuscular disease being handled through the newly opened Stoke Mandeville Rehabilitation Unit.

One feature of both the geriatric and pediatric hospitals that I found of interest was the "Long

Stay Annexes." In the case of the young these are for long term disease and have teaching facilities. For the old, the Long Stay Annex has been used for selected confused patients, sufficiently fit physically to be looked after in part by a few nursing aides and by other patients who become interested and protect them. The Long Stay Annexes also house the frail "over-aged" patient who is competent mentally but without family and unable to care for his own needs.

The Follow Up Scheme

An effort is made to return as many patients as feasible to their own homes. No bedfast patient or patient in pain is ever sent home, but such patients as those with terminal cancer, requiring a great deal of nursing care have been returned under the follow up scheme. If it is possible to relieve their symptoms, improve their nutrition, and treat their anemia, they can and are sent home until readmission becomes necessary.

The Follow Up Scheme approaches the chronic patient as a social problem giving him what Dr. L. Z. Cosin, Director of Cowley Road Hospital; F. R. C. S., England; describes as "The dynamic quadruple assessment—pathological, sociological, psychological and assessment of the residual physical disability" with the provision of continued care from the Geriatric Unit. This continued care may include physiotherapy, occupational therapy and Day Hospital. It is supplemented by continued care from the community in the form of voluntary visitors, Meals on Wheels, social clubs, District Nurses, Health Visitor's education, home helps, municipal transport, friendly neighbors and the General Practitioner.

Combined, these services facilitate the resettlement of a large proportion of patients, even if they live alone on some occasions.

Beds per Thousand Population

The idea of large custodial institutions for the aged and infirm under the hospital authority (National Health Service) is beginning to give way to smaller, far more active Geriatric Units with appropriate Long Stay Annexes for Frail Ambulant and Senile Confused Cases. The ambulant patients become more and more the responsibility of the local social welfare authority.

Specifically, Cowley Road Hospital Geriatric Unit is serving a population of 250,000, with a total of 350 beds or 1.4 per thousand. Of these about 100 (0.4 of a bed per thousand) are the acute geriatric section. The other 250 beds consist of 50 Senile Confusional (40 Female and 10 Male), 150 Frail Ambulant and 50 permanently bedfast. Dr. Cosin believes the latter figure should be considerably reduced in the future.

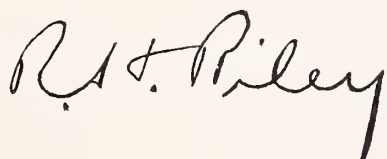
Relationship of the General Practitioner

In Oxford, the Cowley Road Hospital Geriatric Unit is an integral part of the teaching hospital drawing 25 to 30 per cent of its admissions from The United Oxford Hospitals and Radcliffe Infirmary. The rest come from the medical practitioners' referrals and the general hospitals.

A close liaison is maintained with the Practitioner and the Geriatric Unit through the Follow Up Clinic and the Out-Patient service so readmission, when necessary, can be smoothly arranged. Dr. Cosin says the General Practitioners are responsible for the day-to-day care of geriatric patients under rehabilitation in the Long Stay Annexes, especially in rural areas.

Although we cannot see merit in the overall system of National Health Insurance as practiced in Great Britain, nevertheless, it seems to me that in the field of chronic illness, the English have advanced quite rapidly. Rehabilitation has been the keynote of their program. It surprised me to find that rehabilitation of the degenerated senile patient who is irresponsible mentally but physically still active has been successful in almost 25 per cent of cases and that almost all incontinent patients, in the belief of the English, can be retrained.

There is much in the rehabilitation of the aged and chronically ill that neither the English nor we know, but they have explored the field enough to be confident that it offers many unexpected possibilities. This is Maryland's challenge.



Director

ALCOHOLISM, A MEDICAL AND A SOCIAL PROBLEM

PAUL V. LEMKAU, M.D.*

It is trite to point out that alcoholism is no new problem in society. Yet it is perhaps necessary that it be done to make clear at the outset that it is not something to be easily managed by a turn of the "modern" medical hand. Alcoholism is not a specific disease for which we can hope to find a specific cure in the presently foreseeable future. It is a symptom of social unrest and psychological and possibly physiological maladjustment to begin with. In its acute stages alcoholism is, of course, a tissue intoxication or deprivation syndrome. The chronic states of deterioration and psychosis, which follow long periods of inadequate living, neglect of diet and tremendous imbibition of alcohol, are secondary to brain tissue destruction. The behavior patterns shown in these states are likely to be colored and conditioned by the social ostracism which drives the chronic alcoholic to the flophouse and skid row kind of sodden and unstimulating deteriorative type of life. In this process, there are both direct and indirect damages to other body tissues, but the chief interest, so far as personality function is concerned, lies in the damage to the central nervous system.

There is no conclusive scientific evidence at the present time to settle the question of why some people cannot handle alcohol. Of the 40 to 60 million people who use alcohol in the United States, only less than a million are believed to use it beyond what might be called the "normal" way, though of course there are those who point out that alcohol in the blood stream is not ever "normal." It is not a product of normal internal metabolism, but a drug deliberately introduced; therefore there is nothing "normal" in the ingestion of alcohol whatever. From the purely physiological view this reformers' prohibition point of view is certainly sound. But alcohol has a place in almost all human cultures to such an extent that its moderate and controlled use can hardly be thought of as abnormal when man and his culture are viewed as a whole. The excessive, uncontrolled, and by the individual, uncontrollable,

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use of alcohol is what is usually designated "alcoholism," and the inebriate, "an alcoholic."

The end point between "normal" drinking and "alcoholism" is indefinite, though many attempts have been made to fix the point. Everyone seems to agree that the "turning point" comes long before the social degradation to "skid row" that seems to be the premortal agony of many uncontrolled alcoholics. Some believe the diagnosis, self-diagnosis or medical diagnosis, should be made the first time an individual loses a day at work because of a hang-over. Others feel this is too late—that the problem really was there far earlier, perhaps when the subject or his boss first realized that efficiency was lowered at times because of alcoholic intake. Again, the indicator has been taken as the first time the individual has a "black out," is unable to recall what happened during a period of alcohol consumption. This, too, has been said to be too late, and that the matter should become of concern whenever alcohol is taken with the intent to change the emotional state of the individual, and not only when consciousness itself is obliterated. By this definition, the person who fortifies himself with a cocktail before a difficult conference is an alcoholic, as is the person who takes a drink to overcome the shyness that makes interpersonal relations difficult or otherwise painful for him. Alcoholism is also said to be present when the individual appears to take the drug for the purpose of becoming able to say or do things which he would not do when in a state of full consciousness. Perhaps the most common area of action in this sense is the seeking for kinds of sexual experience which are taboo in our culture. The alcohol is drunk, often on a nearly or fully conscious basis, so as to have a convenient, ready alibi at hand, if society points the finger of guilt at the individual for homosexual or other types of sex behavior not easily tolerated in our culture. This same excuse is prepared for indulging in self-pitying criticism of others; one wife described her husband's carping, constant criticism when drunk as "he can really grind the organ when he's tight." Some drunken wife beaters drink because they want to beat their wives and find themselves too much gentlemen to do it when sober. When alcohol is used in this manner, it seems clear that it is fair to say that the state of alcoholism exists. This discussion of end-points of diagnosis is by no means complete, but it will serve as an indi-

cator of the difficulties of definition encountered. On the other hand, it does not seem too difficult for the objective observer to recognize when drinking is going too far. Countless alcoholics bear witness that recognition or at least admission of the state is far harder for the person actually concerned.

What is the nosological position of the state of alcoholism? Is it a disease to be equated with, say, diabetes mellitus—perhaps more appropriately, diabetes insipidus? There are those who support this view, pointing to as yet inadequate data claimed to indicate that there appears to be an excess of diabetics in families of alcoholics as compared to the general population. It can be said, however, that this hypothesis, even if proved, which it is not, would not account for all cases. There is no demonstration that the carbohydrate metabolism of alcoholics is in any sense unusual. Alcoholism, if it is a disease, is not as clear-cut a one as is diabetes or the other pathological hormonal syndromes.

Alcoholism has also been called an allergic phenomenon, it being asserted that the drug has a specificity for the alcoholic that it does not have for others, that the alcoholic is sensitive to alcohol. There is no evidence for this and, of course, the idea falls down theoretically since specific sensitivities are usually due to much more complicated compounds than C_2H_5OH , and also on clinical grounds. The allergic person is seldom driven to test his allergy by taking larger doses of the allergen, even if it happens to be something as delicious as fresh strawberries. While the allergic theory has little to support it medically, it is, perhaps, useful as an analogy for educational purposes. Analogies are tricky teaching devices, however, and many patients carry away the concept that alcoholism is an allergic condition and not what was intended, namely, that in some respects it is something like an allergic condition.

Alcoholism may be conceived of in terms of a peculiar constitution characterized by autonomic imbalance. This imbalance is of such a character that alcohol acts to restore the balance. The success of the drug, however, carries with it side reactions which eventually make it ineffective and actually detrimental. It is, of course, known that various drugs tend to be substituted for alcohol by alcoholics. Barbiturates, paregoric, paraldehyde, chloral and other drugs, subserve the sedative function equally

well and may be depended upon when alcohol is foresworn or unavailable. These drugs are not so socially acceptable, however, in any case they are less commonly used than alcohol in our culture. The constitutional autonomic imbalance is usually supposed to be hereditary, illustrating a very common tendency to use heredity to explain something even though the evidence supporting its responsibility is simply that nothing else explains the situation either. There appears to be no unequivocal evidence that alcoholism is in any specific or near-specific sense dependent upon hereditary factors. The concept of "lack of will power" which explains so little, would probably fall into this general idea of causation.

It has also been hypothesized that alcoholism is a defense reaction of the person against the appearance of more severe mental diseases such as the paranoid psychosis or schizophrenia. The argument is that if the individual did not have the release of alcoholic sprees for his hostilities and aggressions, he would be forced into more severe personality distortions than alcoholism itself is. There is a little clinical evidence for this, but it is supported by no sound statistical studies. One does occasionally see alcoholic patients who become schizophrenic if withdrawn from the possibility of getting alcohol, but it is extremely difficult to say the schizophrenia was not there before also and could have been diagnosed had the patient been thoroughly studied. The psychoses dependent upon brain tissue destruction by or associated with excessive intake of alcohol often have symptoms reminiscent of other mental diseases, particularly the hallucinosis and the delusions. But it is known that brain trauma can release such psychotic symptoms regardless of the source of trauma, and there appears to be no specific character of alcohol in this respect.

Finally, there is the concept that alcoholism is not a disease at all, but a symptom of other disease, depression, elation, schizophrenia, the neuroses, or psychopathic states. Relating alcoholism to manic-depressive psychosis can explain the "cures" observed occasionally without treatment, since this type of psychotic reaction is known to be, in general, self-limited. Clinically, in my experience, alcoholism is occasionally a presenting symptom in elations or depressions, but it very quickly appears that it does not fit the pattern of gradually progressive increase in drinking of the problem alcoholic, but is more

"punched out" in time. It is, of course, also associated with the predominant mood with its appropriate behavior.

Alcoholism is occasionally associated with the schizophrenic psychosis, but again, except in the vague diagnostic group of simple schizophrenia with such symptoms as social degradation and vagrancy, the symptomatic character of the alcoholism is quite clear. In the group of cases mentioned, diagnosis is extremely difficult. In such cases, particularly when no treatment is known, the physician is likely to choose the most serious of the possible classifications since the issue is often how to get the patient out of circulation and into hospital. Since at the present time, a diagnosis of alcoholism will accomplish this for only a short period, and a diagnosis of psychopathy probably not at all, the psychiatrist or physician may be quite reasonably reduced into labelling the problematical case schizophrenia to secure the desirable result in management of the patient and the acute social situation.

It is hardly worth while to discuss alcoholism and the diagnosis of constitutional psychopathic inferior or "psychopath." This diagnosis is almost always a symptomatic diagnosis based on the a- or anti-social acts of the patient in question. Alcoholism is, from the standpoint of society, a series of asocial acts. If it is combined with such antisocial activities as forging, stealing, possibly sex offenses (a matter requiring more elaboration than there is space for here), violence against persons, etc., then the alcoholism may be diagnosed a symptom of the general personality called psychopathic. It is at present an almost purely empirical diagnosis, though recent work on the effect of deficient maternal care in infancy and childhood may substantiate the possibility of etiological diagnosis in this field in the next few years.

Alcoholism as a neurotic symptom has probably been discussed more than the other categories already taken up. The concept has already been suggested in dealing with the postulated autonomic imbalance discussed earlier. The psychodynamic hypothesis of the etiology of neurosis is that, whatever the basic constitutional level of reactivity, autonomic function can be varied through emotionally charged experiences lived through by the person. If the experiences have negative effect, the autonomic functions are adversely affected so that the

usual neurotic symptoms appear. In some instances, the adverse effects are on the thought and feeling patterns so that tension and obsessive states and chronic anxiety appear. In some cases, alcoholism is resorted to in an attempt to allay the uncomfortable thoughts and physiological overreactions.

Alcoholism is also conceived very much more simply by some, so simply that professional suspicion is at once aroused. Alcoholism is simply conceived of as a habit run wild, simply the gradual increase of drinking until the individual is caught and can no longer escape the net of habit constructed on the basis of a very simple learning theory. Few defend this view, though all agree that if it were not for the opportunity in our culture to get alcohol, alcoholism per se would not be a problem. The symptom might be "foodism" with resultant problems of obesity, or excessive sex activity, or perhaps some type of more or less objectionable reformism, if not some worse outlet.

In summary, theories of the etiology of alcoholism are very many and none of them can be said to be proved. It is highly probable that so complicated a reaction as alcoholism will not be explained on any one theory, but will, like most social-personal reactions of illness, be found to have large numbers of factors combining to force the individual into this syndrome.

TREATMENT THEORIES

Theories of treatment should rest on theories of etiology, but as every practitioner knows, they are likely to be contaminated by empiricism to a very high degree. As physicians, we tend to use what works in treatment, we are frequently more anxious to help than we are to explain why and how our help is effective. Boils were lanced before the theory of inflammation and its microscopic demonstration were completed, and electroshock is used although we are hard put to demonstrate just why it helps patients. Many other examples could be used to demonstrate this familiar practical issue. In the treatment of alcoholism the same empiricism dominates the field. There are some relationships between treatment methods and theories of etiology to be sure, but in most treatments anything that seems to help is grasped and used, and the theory is left to the theoreticians. Nevertheless, an attempt will be made to discuss various therapeutic methods in a some-

what systematic fashion. Although it is true that physicians and psychiatrists treat empirically, the consumer often believes treatment to be specific. In the case of alcoholism, the public, on the other hand, seems inclined to blame the medical profession and perhaps particularly the specialty of psychiatry because there is some insistence on having at least a modicum of theoretical justification for a treatment program. This is a common complaint of the Alcoholics Anonymous group which believes it has a method for producing results and is impatient with efforts of the theoretician to explain how they are obtained. At the outset, it should be made clear that the treatment of acute alcoholic intoxication is not the concern here. There are many methods of detoxifying the patient and restoring acute deficiency of nutriment which deserve exposition, but here the concern will be for the treatment of the chronic condition of drinking immoderately.

Insight therapy aims to aid the patient to reach an understanding of his personality and of the forces which form the basis for the dissatisfactions and maladjustments which lead to the symptom of alcoholism. The etiological theory behind this is, of course, that alcoholism is fundamentally a symptom of some mental illness which can be cured by psychotherapy. This type of therapy, whether performed by a psychoanalyst or by some other type of analytic and synthetic method, has not proved very successful and has led the public and alcoholics in particular, to look askance at psychiatric attempts to cure. The explanation for this situation is not easy to find. One might approach the problem from the point of view that the whole psychogenic hypothesis is a colossal mistake, or at least that it has no applicability in the case of the alcoholic. This would certainly be throwing the baby out with the bath, for the hypothesis does not rest on experience with alcoholism alone, but on the whole field of psychopathology where evidence more favorable to it exists in ample amount. The answer probably lies in two points, first that the alcoholic who can afford psychiatric treatment is either not at that nadir of social disintegration from which he turns with great remorse toward any savior since things can get no worse and he live, or it may be that the alcoholic who can afford the treatments is being urged to accept them by someone who is footing the bill so that he himself is not much concerned. Alcoholics are no-

torious for always verbalizing that they want to stop drinking but failing to carry out their promise to themselves to stop until some critical turning point. All methods of therapy seem to agree that very little success can be obtained with patients who do not wish to be cured.

The second, and possibly more important reason for the failure of psychotherapy with alcoholics is that the psychopathology involved is of a type related to that of the psychopathic personality, a group of cases where psychotherapy is also notoriously unsuccessful. The problem would be stated then in terms of such fixed psychopathology of such deeply repressed origins that it cannot be brought to yield to any analytical type of treatment. Psychiatrists are human and, like other physicians, like excuses for their failures. To psychiatrists, then, this formulation of the problem is likely to be satisfactory though to others it is likely to be seen otherwise. It is probable that the psychiatrist and indeed all medical men frequently fail with alcoholics because they see patients too early, before the lowest point of social degradation and therefore do not have the advantage of the deepest remorse and resolution that would appear to be a sort of agonal response giving a sensitive opportunity for therapy at the "psychological time." The police, the judge, the warden and the member of Alcoholics Anonymous gets the advantage of this agonal response. Hearing Alcoholics Anonymous meetings and reading Alcoholics Anonymous stories gives the impression that "hitting bottom" is part of recovery, though the "bottom" is not equally low for all.

The next medical type of treatment to be considered is based on much more mechanistic and superficial psychology than psychotherapy. It attempts to arrest the drinking through setting up a conditional response of nausea and distaste whenever alcohol is smelled or drunk. The alcoholic, after he has recovered from the acute intoxication, is given alcohol and then made to vomit, usually through the use of apomorphine. The process is repeated until a reflex of vomiting to alcohol is set up and the emetic can be withdrawn from the reflex system. Successes have been reported for the conditional reflex treatment though it is less popular now than a few years ago.

More recently the drug "antabuse" has been used. Antabuse reacts with ketones normally occurring

in the blood during the metabolism of alcohol. A response ensues which is most uncomfortable for the patient. Nausea, retching, flushing are severe; apparently the reaction is not one the patient cares to repeat. The risk to life is small though it must be considered carefully since deaths have been reported. The difficulty in antabuse treatment is that the patient must continue to take the drug in order to have the unpleasant reaction to alcohol. Apparently there are those able and willing to take the drug as an additional insurance against weakening and taking a drink and with these persons "antabuse" appears to aid in maintaining abstinence. The treatment is enjoying a wide vogue at the present time.

There is an additional group of therapies which may be called "replacement treatment," therapies in which something is substituted for alcohol. The substitute may be chemical or psychological. Benzedrine had a vogue and is still used to offset the depressed, tired feeling that the alcoholic can so easily use as an excuse for a drink and to induce the state of "brilliance" the alcoholic frequently has the conceit to believe he shows when drunk or nearly so. Benzedrine has proved a deceitful ally however, since it can lead to addiction of sorts with psychotic aftermath hardly less damaging than those due to alcohol itself. Nevertheless it still has its uses. Sugar in various forms has also been substituted for alcohol, the theory being that the alcoholic at first is responding to a need for quickly metabolizable carbohydrate. Both these and similar methods which have been proposed have the psychological advantage that they are received through the mouth, a matter of some importance in some systems of psychopathology. On the basis of experience in therapeutics, as well as in the light of the known tendency for alcoholics to seek substitutes for alcohol which may be more seriously addicting and socially damaging than alcohol itself, it can be said that the substitution of drugs for alcohol is not generally a successful form of therapy.

Finally, there is the group of psychological replacement therapies in which attachments to people or concepts are used with such emotional force that the tendency to drink is overcome through the satisfaction of the needs of the drinker through other channels. While this type of treatment is very old and is used as a part of therapy by almost all success-

ful psychiatrists in the field, it has been used far more by non-medical than medical persons. Religious conversion experiences have been known to "cure" alcoholics for centuries and some of such cures were permanent, as can be proved in many biographies. At the present time, Alcoholics Anonymous is the recognized and organized instrument in our culture carrying on this type of therapy with conspicuous success. The functioning of this organization has been discussed many times in medical and psychiatric literature. The discussion here will be very brief for that reason.

For drinking, Alcoholics Anonymous substitutes group identification and morale, devotion to a cause reinforced by constant labor and sacrifice for the cause, certain practical and simple moral tenets and pieces of wisdom, and an humble bowing before a "Power" Who can aid the alcoholic to overcome any arrogant pride he may have that he can control himself, not only in regard to alcohol but in other areas of life as well.

The admission that the drinker cannot control his drinking is primary. The concept is that the alcoholic cannot ever again drink. Every introduction begins: "My name is John Doe and I am an alcoholic," usually followed by the story that convinces the man himself that this is a true statement though it contains the admission that this knowledge came only after many, many repeated lessons. This statement is the ticket of admission to Alcoholics Anonymous though it may also be added that there is the implication that there is a sincere wish to stop drinking. Stopping drinking, however, does not change the situation as regards alcoholism—the member *is* an alcoholic and believes he will always be so, even though not drinking.

This admission ticket allows the alcoholic to enter an organization of others with drinking histories and experiences as complete and thorough as his own but who are striving, many with success, for complete abstinence. The similar past experience of the members makes it impossible for the alcoholic to use the excuse "you don't understand"; indeed this excuse of the alcoholic is a recognized mechanism so familiar that reference to it will usually bring a laugh from a group of members. Many other familiar projection mechanisms are useless to the alcoholic once he has admitted his fault in the initial statement "I am an alcoholic." The high

sense of belongingness and of morale has a slight tendency to be exclusive, though this is actively striven against in attempts to keep the organization available to all who need it or have a legitimate scientific interest in it.

The Alcoholics Anonymous member imposes upon himself the duty of helping other alcoholics whenever called upon to do so and many members make enormous personal sacrifices to aid their fellow sufferers in personal ways—arranging hospitalization, lending messages, providing clothing and food and sodging, helping find jobs, etc. This is done frankly for the purpose of helping not only the alcoholic now drunk, but as a means of keeping the sober alcoholic helper abstinent. The person helped is brought to a meeting as soon as possible and there he hears the experiences of others and discussions of the moral tenets and wisdoms of the organization.

These are not very complicated. They demand mainly the absence of deceit of self and of others. "Take it easy," "Live one day or hour at a time," "May I accept what I cannot change" are rather typical. A "personal inventory" is suggested which is to a large extent a recounting of past wrong actions, attitudes and modes of thinking. As noted above, it disposes of some of the common dangerous psychic mechanisms and demands that they be recognized as sick and wrong. The Alcoholics Anonymous member regards himself as having a disease which is effectively held at bay by abstinence, honesty with himself and his fellow A. A. members, by service to others and finally by a belief in God though in no definite theological system.

Humility to admit weakness and knowledge of the weakness of other humans leads to acceptance of need for guidance from a Power beyond man that is, for some members, obviously part of a deep and satisfying religious experience though frequently coming about in a setting of simple camaraderie.

SUMMARY

This paper has attempted to discuss some of the theories of the etiology of alcoholism. For the author, the most appealing one is the psychodynamic one, though in all probability the final answer will be contributed to by research in this area, in physiology and possibly in genetics as well.

Therapeutic methods have been reviewed in terms of psychotherapy of the analytic and synthetic types,

of the use of psychological mechanisms of learning, of substitution of other substances for alcohol, and finally, the substitution of satisfactions arising out of powerful emotional attachments to others, certain moral concepts and wisdoms and a belief in some higher Power.

It would appear that there are many forces that can be used in the control of alcoholism and in its

treatment, but the application of them in the practice in medicine will require a great deal of research.

The paper has not by any means settled the nosological problem of alcoholism as a disease. The definition the paper started with, "it is a symptom of social unrest and psychological and possibly physiological maladjustment," is as good as can be suggested.

* * * * *

SOUTHERN MEDICAL AUXILIARY INVITES WIVES TO MIAMI

The Southern Medical Association meets in Miami, Florida, November 10th-13th, 1952, and all indications are that it will be a meeting to be long remembered. The hospitable Miamians are going all out in planning a delightful social program for the ladies. A tentative Auxiliary program is as follows:

- Sunday, November 9th Special Executive Committee meetings
- Monday, November 10th Luncheon for Past Presidents
Luncheon for Councilors
- Tuesday, November 11th Executive Board Breakfast
General Sessions
Doctors Day Luncheon
Other social activities, including a Fish Fry on the beach
- Wednesday, November 12th . . . General Sessions
Luncheon honoring the President, Mrs. V. Eugene Holcombe, the President - Elect, Mrs. Richard Stover, visiting State Presidents and Charter Members
- Thursday, November 13th Executive Board Banquet

The Auxiliary to the American Medical Association will furnish two of the speakers. Mrs. Ralph B. Eusden, President of the Auxiliary to the A. M. A., will discuss the aims and general program of the Auxiliary, and Mrs. John McCuskey, a vice Chairman, will speak on nurse recruitment.

Councilor for the Woman's Auxiliary to the Southern Medical Association is Mrs. Frank A. Holden, of Baltimore, Maryland, and Vice Councilor is Mrs. Thomas A. Christensen, of College Park, Maryland.

Wives attending the Southern Medical Association meeting with their husbands are cordially invited to attend all activities of the Auxiliary.

ALL RESERVATIONS FOR LUNCHEONS SHOULD BE MADE EARLY.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, August 1-28, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County.....	3	—	1	3	3	—	3	4	2	—	—	—	—	22	2	12	—	2
Anne Arundel.....	5	—	1	—	—	1	2	4	1	—	—	—	—	10	—	4	—	2
Howard.....	—	—	—	—	—	—	—	—	—	—	—	—	2	2	—	—	—	—
Harford.....	—	—	—	2	2	—	3	2	1	—	—	—	—	4	—	2	m-5	—
Carroll.....	—	—	—	—	2	—	—	2	—	—	—	—	—	3	1	1	—	1
Frederick.....	1	—	4	—	13	—	4	4	1	12	—	—	—	1	—	—	—	—
Washington.....	—	—	—	—	—	—	—	1	—	—	—	—	—	7	—	1	—	2
Allegany.....	—	—	—	—	—	—	1	—	2	1	—	—	—	5	—	—	m-1	—
Garrett.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Montgomery.....	—	—	2	—	—	—	7	—	1	—	—	—	1	21	—	2	—	2
Pr. George's.....	1	—	—	—	5	—	4	3	—	1	1	—	1	17	—	3	—	1
Calvert.....	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	—
Charles.....	—	—	—	—	—	1	—	1	—	1	—	—	—	3	—	—	—	—
Saint Mary's.....	—	—	—	3	—	—	—	1	—	—	—	—	—	1	—	—	—	—
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	—	1	2	—	—	—	2
Kent.....	1	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Queen Anne's.....	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	m-1	—
Caroline.....	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	7	—	—
Talbot.....	—	—	—	—	1	—	—	—	—	—	—	—	—	4	2	8	t-1	—
Dorchester.....	—	—	—	—	7	—	1	—	1	—	—	—	—	—	—	—	—	1
Wicomico.....	—	—	1	1	—	—	—	—	1	—	—	—	—	2	—	20	—	1
Worcester.....	1	—	—	—	—	—	—	1	—	—	—	—	—	1	1	1	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Total Counties.....	12	0	9	9	33	2	25	23	11	15	1	1	5	113	7	61	—	15
Baltimore City.....	8	0	1	2	10	0	25	10	0	6	0	0	2	104	15	581	—	8
State																		
Aug. 1-28, 1952.....	20	0	10	11	43	2	50	33	11	21	1	1	7	217	22	642	—	23
Same period 1951.....	33	2	12	13	274	1	63	15	8	7	2	4	28	155	24	664	—	16
5-year median.....	21	8	6	—	31	4	46	33	13	15	4	2	133	208	76	716	—	29
Cumulative totals																		
State																		
Year 1952 to date.....	2731	7	825	162	9058	68	886	55	29	821	15	12	151	1889	125	4848	—	477
Same period 1951.....	2671	31	837	177	5271	44	3550	32	35	708	10	21	340	1806	232	4773	—	366
5-year median.....	3026	146	380	—	2889	92	1175	58	48	862	22	31	902	1919	921	4988	—	483

m = malaria; all were contracted outside the U. S. A. except 1 from Aberdeen Proving Grounds, residence unknown.

t = tetanus.

BLUE CROSS AND BLUE SHIELD

BLUE SHIELD

HUGH J. JEWETT, M.D.*

The revisions in our Blue Shield Plan which were discussed at the April meeting of the House of Delegates and at subsequent meetings with component societies, will become effective September 1.

The revised Plan is the result of State-wide co-operation of all of us, as individuals and as groups, to bring about a better prepayment medical care program for this area.

It was only natural that not long after the Plan got underway in November of 1950 the need for certain adjustments and improvements began to become apparent.

By mid-summer of 1951, sufficient experience had been gained by the Plan for its Board of Trustees to consider changes which would make the Plan more acceptable to the public and more equitable to the physicians.

It was felt that there should be a revision in the subscription charges, particularly in the rate for family subscribers, and that the income limit for service benefits for this group of subscribers should be increased.

It was also decided to adjust the Schedule of Benefits, eliminating the categories and setting up a standard type of fee schedule which would be more equitable to physicians, and also to subscribers whose incomes exceeded the established limits. This revision in benefits was undertaken by a committee headed by Dr. I. Ridgeway Trimble. Based on this new schedule of fees, a study of necessary subscription charges was undertaken by the Plan's actuaries.

The Board of Trustees accordingly asked the Council of the Faculty for permission to increase the family income limit. The Council gave approval, in principle, but referred the matter to the House of Delegates at the annual meeting in April of 1952. The component societies of the Faculty thereafter considered this proposal and an overwhelming majority approved an increase in the family income limit to \$4,000.

Under the revised Schedule, a separate benefit

has been set for each type of operation, ranging from \$10.00 to a maximum of \$200.00.

Among benefit changes, the benefit for normal obstetric delivery has been changed to \$80.00 and will not include pre-natal or post-natal care beyond the hospital stay. (Family subscribers enrolled before September 1, 1952, will receive obstetric benefits under their original membership certificate, instead of the revised certificate, until June 1, 1953.) This revision makes possible a substantial reduction in the subscription charge for families, and it is hoped that this lower rate will make the Plan more attractive to this group.

The new monthly group rate for a one-person membership is \$.90, for husband and wife, or one parent and one child (no obstetrics) \$1.80, and for the family (husband and wife and all children under 19 years, including obstetrics) \$3.00.

The State Insurance Department has given its approval to the revisions in the Plan, and the administrative staff is prepared to offer the new program to all Blue Cross groups as rapidly as possible.

Every Blue Shield subscriber is receiving an announcement of the changes, together with a new membership certificate.

A new instruction manual for Participating Physicians has been prepared, including the complete new fee schedule, and a copy will be mailed to all physicians prior to September 1st.

A revised claim form also has been developed, intended to simplify the paper work for physicians in handling cases under the Plan.

The Board of Trustees, the Plan's administrative staff, and many others less directly concerned have spent much time and given careful study to this matter, and every effort has been made to make the Plan attractive to the public and equitable to physicians. It may not be perfect in every respect, but those who are directly responsible for its operations feel that it is a much improved Plan, and that real progress can now be achieved in extending prepaid health protection to the people of Maryland.

* President, Board of Trustees, Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

PROGRAM

Mrs. JOHN G. BALL, *Chairman*

Do you know the "Program" of our Maryland Auxiliary and of its parent body, The Woman's Auxiliary to the American Medical Association?

How can we best work together to assist the Faculty and the American Medical Association, to cultivate friendly relations among physicians' families and do a good job with Public Relations, so we may truly be an "Auxiliary"—or a help? Our first aim in all our meetings is to keep posted on the various phases of the "Program" as indicated below! There are many subjects and many interesting ways for Chairmen to present them so that the informal social meeting is not lost.

The American Medical Association has a wealth of material which can be obtained, sorted and organized into informative, newsy briefs. Subjects on the Aging, Chronically Ill, Narcotics Addiction, A. M. A. Services, articles in the popular press such as, *I'm a Doctor and I'm a Human*, are all possible meeting material.

A popular part of the program for Maryland during the coming year will continue to be, "Nurse Recruitment." Arrange to show the film, "Girls in White," to your Junior High Girls. We can now obtain this film from National without charge. Plan a follow-up tea or get together for any girls who are interested! Encourage the ideals of service to your own community and of Nursing as a responsible profession which is more than "just a good job."

Civil Defense will be extremely important in all of our communities. The American Medical Association *expects* us to lead in this field! Auxiliary members should take the Red Cross First Aid Courses, give blood, and help with our block questionnaires. Advice on good program material can be obtained from your local Civil Defense Office. Remember that doctors' wives are needed in the Casualty Clearing Stations as Volunteers!

"Public Relations" is interwoven throughout the Auxiliary Program but it comes to the fore at the County Fairs. Try to plan an Auxiliary Health Booth at which American Medical Association literature can be distributed during your Fair.

This is an important election year, check your Auxiliary members and their husbands to be sure they are registered voters and *do vote*. What about the other doctors in your community? They and their wives can find the time to vote, if they are reminded!

Remember that your State Officers are ready and willing to help with suggestions or material for your Component Auxiliary. Your State President would be happy to attend your County meeting. Plan your 1952-53 Program *early* and include some or all of these suggestions.

* * *

AMERICAN EDUCATION

We are all gradually awakening to the widespread left-wing effort to communize or socialize not just the medical profession but our entire Country through "thought control" in all of the available means of communication, including schools—from kindergarten through college, literature, the theatre, movies, public libraries, organizations and even our Churches and Sunday Schools. To stop this infiltration we must first inform ourselves by reading such articles as these from which we quote.

I. "The United Nations Charter authorizes a host of *autonomous specialized* agencies, such as the *International Labor Organization*, the International Court, the UN Economic and Social Council, and the UN Educational, Scientific, and Cultural Organization (UNESCO). This latter organization has sponsored nine booklets under the title: '*Toward World Understanding*.' They deal with the ideas to be *inculcated* in our children from kindergarten through grade school. One pamphlet is on *The U.N. and World Citizenship*; another, *The Influence of*

Home and Community on Children Under 13 Years of Age.

In describing this series, Congressman Wood states: 'The program is quite specific. The teacher is to begin by eliminating any and all words, phrases, descriptions, pictures, maps, classroom material or teaching methods of a sort causing his pupils to feel or express a particular love for, or loyalty to, the United States of America. Children exhibiting such prejudice as a result of prior home influences—UNESCO calls it the outgrowth of the narrow family spirit—are to be dealt an abundant measure of counter propaganda at the earliest possible age.' (*The Greatest Subversive Plot in History—Report to the American People on UNESCO, John T. Wood, Congressional Record, October 18, 1951.*)

"UNESCO urges that teachers of children from 3 to 13 shall not take up American history and geography but concentrate on 'universal history and geography' until the children are freed from their 'nationalist prejudices.' Following this advice, some schools in eastern Pennsylvania 'have dropped American history as a standard, required subject'"—*From Challenge To Socialism, Marjorie Shearon, February 1952.*

II. "Miss Helen E. Haines has more to do with determining what books go on the shelves of your public libraries than anyone else in the whole country. A few months ago Columbia University Press brought out a new and revised edition of Miss Haines's magnum opus, *Living With Books*. Since it was first published in 1935 *Living With Books* has become the Bible of librarians everywhere. In the 10,000 or more public, private, high school and college libraries of the United States, no textbook for librarians is more highly regarded. It is as the *Bookman's Manual* declared, 'the standard compendium of the art of book selection.'

"There is, however, a profound—and dangerous—difference between the 1935 edition and that of 1950. For at some point in the intervening years Miss Haines 'discovered' Soviet Russia and the Communist philosophy. Like all new converts, she has lost no opportunity in revising her book to play up her discovery. In fact, the major impression I get from a comparison of the original with the revised edition is the strong pro-Soviet bias of the latter. Miss Haines may think that she is still objective, but in

fact she has now become a propagandist for the Stalinist way of life.

"The prestige enjoyed by Miss Haines's book has carried over to this new edition. Without doubt large numbers of libraries are already selecting books based upon her recommendations, without knowing that the cards have been stacked."—*From A Slanted Guide To Library Selections. The Freeman, January 1952.*

III. "With varying degrees of success, all four of the major aims of the communists in Hollywood were achieved: (1) Hollywood was 'milked' for vast sums of money. (2) Communist causes and fronts were glamorized by Hollywood celebrities. (3) The extent to which the communist line was smuggled into the script of films is debatable. Certainly, such pictures as *Song of Russia*, *Mission to Moscow*, and *North Star* were saturated with pro-Kremlin propaganda. (4) The communists for years controlled the Screen Writers Guild, even during the incumbency of the self-proclaimed anti-communist Emmet Lavery. The failure of the communists to capture the Hollywood unions took vigorous fighting on the part of the loyal Americans like Roy Brewer in the labor movement." (This article lists an alarming number of your favorite *movie* stars who are communists or communist sympathizers. The names will shock you.)—*From Did The Movies Really Clean House? American Legion Magazine, December 1951.*

* * *

AUXILIARY NEWS

Mrs. Howard W. Ash, Past President of the Woman's Auxiliary to the Frederick County Medical Society, is now living in Evanston, Illinois, while Dr. Ash completes a two year residency in Ophthalmology at the Eye and Ear Hospital there.

The New Edition of our "Auxiliary Handbook" is now available at thirty-five cents a copy or three for a dollar! Every Auxiliary will probably want this guide for its Officers and Chairmen. It is obtainable from The Woman's Auxiliary to the American Medical Association, at 535 North Dearborn Street, Chicago 10, Illinois.

Miss Margaret Wolfe, for so long the wonderful Executive Secretary of the National Auxiliary and a doctor's wife, herself, is to our great regret, re-

tiring. The new Executive Secretary to whom we will all be writing for material and help is Mrs. Dorothy K. Middleton, at the American Medical Association Headquarters in Chicago.

The Baltimore County Auxiliary held a banquet jointly with the Medical Society in June, and are now planning a "Barn Dance" perhaps in costume, for fall!

Our State President, Mrs. Charles H. Williams, purposely delayed her Post-Annual Board Meeting until her return from the National Convention of the Woman's Auxiliary to the American Medical Association which was held in Chicago in June. We understand that she brought back a great many new ideas to her Officers and Chairmen for Auxiliary work.

* * *

MORE THAN MEETS THE EYE?

"If Mrs. Alice Tisdale Hobart had managed to devise a suitable ending for her 402 page novel, *The Serpent Wreathed Staff*, about sixty pages sooner than she did, a tolerant critic would be able to say that she had written a faulty but highly interesting story of human conflicts and loyalties.

"Unfortunately, however, the latter part of the book degenerates swiftly and recklessly into an amazing propaganda piece for National Compulsory Health Insurance. The last forty or fifty pages sound as if Mrs. Hobart knocked them out hastily at a

desk piled high with pamphlets, speeches and news releases handed out by Federal Security Administrator Oscar Ewing and The Committee for the Nation's Health.

"This uncraftsmanlike abuse of artistic license, added to some of the implications built up in earlier pages, creates the impression that the entire novel was designed as a subtle presentation of the case for Socialized Medicine. As a result, Mrs. Hobart undermines much of the validity that does exist in some of the earlier parts of this book about doctors, modern medicine and a changing world."—From Book Review mailed us by the American Medical Association.

* * *

QUOTABLE QUOTES

"Bad politicians are elected by good people who do not vote," from a speech made at the recent National Auxiliary Convention in Chicago.

"Put none but *Americans* on guard tonight." (Don't Elect an "America-Last" President!)—George Washington.

"By 1954, medical graduates will have increased by 22 per cent over 1940. By 1960, the year of the alarming shortage feared by Washington politicians, we'll have more doctors in proportion to population—and better ones—than we have today."—*What about This Doctor Shortage?*—Readers Digest, June 1951.

* * * * *

HELP GET OUT THE VOTE

by using

BUMPER STRIPS

on your car

AVAILABLE AT

MEDICAL AND CHIRURGICAL FACULTY

Ancillary News

DENTAL SECTION

A. BERNARD ESKOW, D.D.S., *Journal Representative*

BALTIMORE CITY DENTAL SOCIETY

The regular scientific sessions of the Baltimore City Dental Society were brought to a close for the summer at the May meeting. As is customary the regular outing was held at the Country Club of Maryland on June 17. It was a day of rest and relaxation for the men and included the usual golf, horseshoe pitching, tennis, softball, etc. It was followed by a catered dinner at which time for second year winners on two-year permanent trophies were

announced. For golf it went to Dr. Edward (Middlecoff) Stinebert and for horseshoe pitching to Dr. Guy Lyon. The attendance was excellent and all the men seemed to have had an enjoyable day.

The city dental society is now busy at work getting ready to play host to the Maryland State Dental Association for its Semi-Annual Meeting sometime in the latter part of September. The details of the meeting have as yet not been released. However, they usually include both a scientific and social section.

NURSING SECTION

M. RUTH MOUBRAY, R.N.,* *Journal Representative*

PURPOSE OF RED CROSS VOLUNTEER NURSE'S AIDE PROGRAM

Noting the steady expansion of the volunteer nurse's aide program during the past 2 years, the Red Cross this month issued a statement to clarify misunderstandings that have developed concerning the objectives and limitations of the program and to reemphasize the responsibilities of professional nurse leadership in safeguarding standards.

While the volunteer nurse's aide program was familiar to many nurses during World War II, when more than 215,000 aides gave nearly 43 million hours of service, it is apparent that the present-day program is new to many nurses.

The volunteer nurse's aide program is designed to prepare a group of women and men not previously trained or engaged in any form of nursing practice to give volunteer assistance to professional nurses. These trained volunteers may give service in hospitals, clinics, in the Red Cross Blood Program, or with public health nursing organizations. They also

constitute a reserve to help in disasters, epidemics, and similar emergencies.

The Red Cross is not responsible for training aides for vocational or paid employment and does not consider its training course suitable for this purpose.

Since the volunteer nurse's aide program involves technics of nursing that must be directed and supervised by professional nurses, the local Red Cross chapter committee responsible for the program is composed of both nurses and non-nurses. This committee determines the need, selects and assigns the aides, and interprets the service to the general public. The professional nurses on the committee:

1. Assist in evaluating the nursing needs when requests for nurse's aide service are received.
2. Interpret the program to professional people and maintain relationships with professional groups in the community and in the institutions where aides work.
3. Approve hospitals or health organizations for training or for service to assure adequate professional supervision and acceptable standards of nursing care.
4. Approve qualifications of volunteer nurse's aide instructors.

* Administrator, Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations.

5. Advise on the adequacy of classrooms and working equipment.

All teaching material for volunteer nurse's aides is prepared by the Red Cross nursing staff with the advice of national leaders in the medical and nursing professions.

1952 BIENNIAL NURSING CONVENTION

During the week of June 16-20 at their Biennial Convention a new structure of national nursing organizations was achieved. There is now a revised and expanded American Nurses' Association and a new National League for Nursing. The A. N. A. has nurse members only, while the N. L. N. has non-nurse and agency members as well as nurses. The purpose of the A. N. A. is to foster high standards of nurse practice and to promote the welfare of nurses through the coordinated action of organized professional nurses. The purpose of the N. L. N. is to foster the development and improvement of organized nursing services and of education for nursing, through the coordinated action of nurses, allied professional groups, general citizens, community agencies and schools, to fill nursing needs of people.

Maryland nursing organizations are planning for similar reorganization on the state level.

Mrs. Elizabeth K. Porter, R.N., of Cleveland, Ohio, was reelected president of the A. N. A. and Miss Ruth Sleeper, R.N., of Boston, Massachusetts, was elected the first president of the new N. L. N. Of special interest to people in Maryland were the elections of Miss Miriam Robider of Baltimore as Chairman of the Private Duty Section of the A. N. A. and Mr. George W. Mason of Baltimore as a director of the N. L. N.

Student nurses in attendance at the Biennial Convention decided to create an independent nursing council. This will be formed under the sponsorship of the coordinating council of the A. N. A. and N. L. N. More than 1,000 students attended, approximately 50 of whom were from Maryland schools of nursing.

One of the most important actions at the convention took place when the nurses supported a draft of nurses if required during a national emergency. The A. N. A. House of Delegates approved, with only a few opposing votes, a resolution which authorized the Board of Directors of the A. N. A. to approve legislation, if introduced into Congress during a national emergency, which would enact a selective service for nurses.

* * * * *

Not the *Farm Vote* . . .
The *Big-City Vote* . . .
The *Labor Vote*
Or any *Party Vote* . . .

THE FAMILY VOTE

Will elect the Next President

Politicians talk a lot about this and that "bloc" of voters being decisive factors in this election. So do all the pollsters. You can't blame them for trying to dope it out that way in advance . . . but . . .

YOU know you're going to vote your own sweet way when you get behind that voting booth curtain—that where you live or work hasn't got a blankety-bloc thing to do with how you'll vote. You'll vote for what you believe to be in the best interests of your family—your kids—and your kid's kids.

So YOU know that this year—as always—it will be the FAMILY vote that really decides things. And families are working as never before to make sure every American votes. Right now in millions of American families, everyone from Little Sis to Grandma is pitching in to remind every eligible American to register to make sure of the opportunity to vote. And then they'll tackle the job of getting out the vote of every member of America's 44,000,000 families. They're the biggest "bloc" in America—they ARE America!

If your family is already working at the job—congratulations! If you aren't, talk it over at supper tonight, and pitch in tomorrow.

YOUR DOUBLE DUTY . . .

Vote Yourself and Help Your Neighbor Vote!

THE DOCTOR JULIUS FRIEDENWALD MEMORIAL LECTURE

ANNOUNCEMENT

The Doctor Julius Friedenwald Memorial Lecture will be given by

DR. WALTER C. ALVAREZ

Professorial Lecturer at the University of Illinois Formerly of the Mayo Clinic

on

Some Curious Digestive Syndromes and Their Causes

On Thursday, October 9th, 1952, 8:30 P.M.

At the University of Maryland, School of Medicine Chemical Hall—Main Building
Northeast Corner of Lombard and Greene Streets

As a fitting memorial to the late Doctor Julius Friedenwald, a lectureship was established at the School of Medicine of the University of Maryland. A Committee consisting of Dr. Maurice Feldman, Dr. Maurice Pincoffs, Dr. Walter Wise, Dr. Samuel Morrison and Dr. H. Boyd Wylie, Dean of the School of Medicine, ex-officio, was appointed by the University of Maryland to administer this yearly lectureship.

It was felt that the establishment of a yearly lectureship with the presentation of a gastrointestinal subject would be a lasting tribute to the late Dr. Julius Friedenwald. It was this specialty to which he devoted his life and to which he contributed so much. Dr. Friedenwald's ability as a doctor was recognized by all. He was a scientist, teacher, writer and a physician who not only loved but truly lived for his profession. He was an inspiration and guide to all who were fortunate enough to be associated with him. In addition to his professional attainments in Gastroenterology, Dr. Friedenwald endeared himself in the hearts of his colleagues and fellow citizens. In his memory, this yearly lecture is given at The University of Maryland, School of Medicine, where he served so faithfully as Professor of Gastroenterology.

The first lecture was given by Dr. George Eusterman of the Mayo Clinic in 1946; the second in 1947 by Dr. Walter L. Palmer of the University of Chicago; the third in 1948 by Dr.

Frank H. Lahey, of the Lahey Clinic of Boston; the fourth in 1949 by Dr. Henry L. Bockus, University of Pennsylvania Graduate School of Medicine; the fifth in 1950 by Dr. Andrew C. Ivy, of the University of Illinois, Chicago; the sixth in 1951 by Dr. Albert F. R. Andresen, State University Medical Center, College of Medicine, New York. The seventh lecture will be given by Dr. Walter C. Alvarez, October 9, 1952.

Dr. Alvarez, formerly of the Mayo Clinic, is now Professorial Lecturer at the University of Illinois.

Dr. Alvarez has been an intensive research worker. His early interest in intestinal physiology led him to establish the gradient theory of the gastrointestinal tract, with all its implications in terms of tonicity and peristalsis. He published a treatise on "Mechanics of the Digestive Tract." Later his work on "Nervous Indigestion and Pain," appeared and was widely read. His most recent book, "The Neuroses," has been favorably reviewed. These books mark his interest and approach to the large field of psychiatry in gastroenterology.

He is a past president of the American Gastroenterological Association and a recipient of the Julius Friedenwald Medal. The latter is given to a member of this Society who has distinguished himself as a Gastroenterologist of the highest standing.

TAKE NOTE OF YOUR AUGUST JOURNAL!

J. Albert Chatard, M.D.

Just a few words of "congratulations" to the Editor and his Associates, and the office staff that produced the August number of the Journal, which contains part of the Transactions of the Annual Meeting, 1952. I feel this number alone will do more good than all the notices, talks and warnings that we have brought out for years.

The complete work and reports will now reach the whole membership and not the few who attend but may not listen or take in the work of the Faculty for each and every member. Approximately twenty-five hundred copies of the Journal have been mailed out to the membership. Of this number, some will lie unopened, or some, if removed from the envelope, will lie on the desk for some time before going into the scrap basket. Others will be looked at but not read or digested. Like the "Bible," the words will fall by the wayside and take no roots.

I hope the greater portion of the members will read and absorb the matter included and bring forth "good fruit" in their appreciation of what is done for "so many by so few."

ERRATA

Corrections to be made in the minutes of the House of Delegates meetings of April, 1952:

August, 1952, MARYLAND STATE MEDICAL JOURNAL, Volume 1, No. 8, Page 382, column 2, top of page, for insertion in the first session, House of Delegates minutes, Tuesday, April 29, 1952, the following Amendments to the Constitution and By-Laws should be inserted just before the wording, "The meeting was then adjourned for a five minute recess."*

Chapter VIII. Standing Committees.

Section 1. (Paragraph II) The standing committees, WHICH ARE to be named by the President, ARE: Nominating Committee, RESOLUTIONS COMMITTEE.

(Paragraph III) Standing Committees, organized as hereinafter provided, are: House Committee, Finance Committee, PROFESSIONAL CONDUCT COMMITTEE AND RESOLUTIONS COMMITTEE.

Section 8. PROFESSIONAL CONDUCT COMMITTEE. This Committee shall consist of the five immediate Past Presidents of the Medical and Chirurgical Faculty with the SENIOR PAST PRESIDENT as Chairman of the Committee. The function of this Committee will be to hear legitimate grievances against members of the Society, examine the facts of the grievances and make recommendations as to their disposition to the Council of the Faculty.

Section 9. RESOLUTIONS COMMITTEE. THE RESOLUTIONS COMMITTEE SHALL CONSIST OF FIVE MEMBERS TO BE APPOINTED ANNUALLY BY THE PRESIDENT OF THE MEDICAL AND CHIRURGICAL FACULTY, WHO SHALL ALSO DESIGNATE THE CHAIRMAN OF THE RESOLUTIONS COMMITTEE. THIS COMMITTEE SHALL BE CHOSEN FROM THE HOUSE OF DELEGATES, AND SHALL BE APPOINTED AT LEAST 30 DAYS BEFORE THE ANNUAL MEETING OF THE HOUSE OF DELEGATES.

ANY NEW BUSINESS INVOLVING A QUESTION OF POLICY, WHICH HAS NOT PREVIOUSLY BEEN CONSIDERED BY THE COUNCIL OR THE HOUSE OF DELEGATES, SHALL BE REFERRED TO THE RESOLUTIONS COMMITTEE FOR CONSIDERATION, BEFORE BEING ACTED ON BY THE HOUSE OF DELEGATES. THE RESOLUTIONS COMMITTEE SHALL REPORT TO THE HOUSE OF DELEGATES AT THE TIME INDICATED BY THE CHAIRMAN OF THE HOUSE OF DELEGATES.

* Adopted by the House of Delegates, Wednesday, April 30, 1952.

ERRATA

August, 1952, MARYLAND STATE MEDICAL JOURNAL, Volume 1, No. 8, page 384, column 2, minutes of the House of Delegates, 3rd session, Wednesday, April 30th, the following resolution, which should be inserted for the one erroneously published in the August Journal, was presented by Dr. Harry F. Klinefelter, Jr., and adopted by the House of Delegates, in session on April 30, 1952.

*RESOLUTION

WHEREAS, the important legislation for the creation of a federal Department of Health, has been debated before the Sub-Committee on Reorganization of the Senate Committee on Government Operations, and

WHEREAS, this legislation is expected shortly to be considered by a House Committee in further hearings, and

WHEREAS, the American Medical Association approves the principles of conservation of medical man power and coordination of federal medical activities in a Department of Health, and

WHEREAS, it is agreed that the coordination of competing federal medical services would result in greater efficiency and economy and make for conditions better for doctors and for the public, therefore

BE IT RESOLVED, that this body shall respectfully ask the American Medical Association to further and more fully consider means to bring about such coordination by either initiating or supporting such legislation as seems indicated, and

That copies of this resolution be sent to Dr. John W. Cline, President of the American Medical Association, and to the National Doctors Committee for Improved Federal Medical Services, 15 West 46th Street, New York 36, New York.

It is suggested that these pages be taken from your Journal and inserted as designated, so that the minutes will be correct. It is regretted that the latter part of the minutes were omitted and the error was made in the Resolution.

Maryland

STATE MEDICAL JOURNAL

Medical and Chirurgical Faculty of the State of Maryland

VOLUME 1

October, 1952

NUMBER 10

Blue Cross-Blue Shield Membership Enrollment Available to Members of the Medical and Chirurgical Faculty November, 1952

The annual Blue Cross-Blue Shield membership opportunity will take place during the month of November. Throughout this time, applications for new members and for present subscribers wishing a change in status will be accepted for faculty members and their employees. The latter part of October you will receive a letter from Blue Cross-Blue Shield presenting information covering the details of enrolling along with explanatory material and application cards.

As most of you know, the Blue Shield Plan has been revised in several important respects. While Blue Shield continues to pay both medical and surgical benefits, it is important that you and your employees take note of the following important changes:

1. Service benefits are now available to married subscribers whose total income is \$4,000 or less. This represents an annual increase of \$400.00 over the former allowance.
2. The schedule of surgical benefits has been revised so as to provide \$200.00 for a number of the more difficult operations and allowances for some common surgeries such as appendectomies and tonsillectomies have been increased.
3. In order to conform to the standards set by the Wage Stabilization Board providing automatic approval for employers who wish to pay all or part of the coverage for their employees, medical benefits have been revised to pay \$15.00 for the first day, \$5.00 for the second and third day each and \$4.00 for the fourth through the twenty-first day each.
4. Changes in Blue Shield benefits have entailed a change in subscription charges as follows: individual \$.90; two person \$1.80; family \$3.00. The new rates and benefits under Blue Shield became effective September 1, 1952.

For additional information concerning the advantages of the Blue Shield Plan, please consult the folder which will be sent you by the Blue Cross-Blue Shield office.

The Blue Cross Plan which now has an enrollment of more than 850,000 subscribers was favorably revised as of December 1, 1951. While the majority of faculty members are probably familiar with the details of Blue Cross, a summary of the main features of the Plan is presented for your convenience.

For subscribers using semi-private rooms, Blue Cross pays the bill in full for the customary services regardless of cost. These services are:

- a. Room, meals, special diets
- b. General nursing care
- c. Operating room

- d. Anesthesia given by hospital employee
- e. Standard drugs and medications
- f. Laboratory examinations (when a necessary part of in-patient care)
- g. X-ray examinations
- h. Electrocardiograms
- i. Physiotherapy
- j. Casts and dressings
- k. All other customary hospital services

Subscribers using private rooms in member hospitals receive a credit of \$7.00 a day toward the room charge plus a credit of 75% of the charges for all customary hospital services.

As in the case of Blue Shield all basic information concerning Blue Cross will be contained in folders which will reach you direct from the Blue Cross office.

Continued support of the Blue Cross—Blue Shield Plans is still the best means of enabling citizens of Maryland to pay for their health care on a voluntary basis. The success of Blue Cross—Blue Shield is universally used as a most effective counter-proposal in discussions and debates wherever the need for some enforced health program is advocated. Blue Cross—Blue Shield, operating as they do on a non-profit basis with the cooperation of the medical profession and the hospitals, has proven to be the most inexpensive method of providing comprehensive benefits to persons who wish to maintain freedom of choice and opportunity in managing all needs pertaining to their health.

* * * * *

DOCTOR, TAKE THIS HOME TO YOUR WIFE!

Be a member; participate in our program of health education and of support for American principles, fighting Socialized medicine.

Application for Active or Associate Membership

IN THE

**Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland
THROUGH THE**

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

1211 CATHEDRAL STREET, BALTIMORE 1, MARYLAND

1. NAME.....
2. ADDRESS.....
3. SPONSORING PHYSICIAN.....
4. CHECK TYPE of MEMBERSHIP { Active ☐
Associate ☐
5. DATE.....

Application must be accompanied by membership fee.

Active Dues \$5.00 (wives of doctors who are members*)

Associate Dues \$3.00 (mothers and sisters of doctors who are members*)

* Members of the Baltimore City Medical Society and the Medical and Chirurgical Faculty.

Scientific Papers

TRANSACTIONS

Additional scientific papers which were presented during the April, 1952, Annual Meeting of the Medical and²Chirurgical Faculty and are a part of the Transactions, will be published in subsequent Journals and so noted on the articles.

Contraindications to ACTH and Cortisone¹

Panel Discussion

DR. R. CARMICHAEL TILGHMAN²: This afternoon's meeting will be a Panel Discussion on ACTH. I would like to introduce those participating and then turn the meeting over to the Moderator. The Moderator is Dr. Warde B. Allan, Associate Professor of Medicine at Johns Hopkins University, School of Medicine. Dr. A. McGehee Harvey, Professor of Medicine at Johns Hopkins University School of Medicine, and Physician-in-Chief at the Johns Hopkins Hospital. Dr. John C. Krantz, Jr., Professor of Pharmacology, University of Maryland, School of Medicine. I'd like to turn the meeting over to Dr. Allan, the Moderator.

DR. WARDE B. ALLAN³: Dr. Tilghman, Members of the Faculty and Guests, I have been asked to act as moderator in the panel discussion this afternoon. The subject that has been announced is "Contraindications to ACTH and Cortisone," and I assume that Dr. Krantz and Dr. Harvey will cover this subject thoroughly. However I am taking the liberty of suggesting

for the sake of subsequent discussion and for questions from the floor that we will include in the title "Indications for ACTH and Cortisone."

In the past sixteen years, we have seen an amazing and revealing period of therapeutic agents and procedures that far surpass anything that has been seen in any previous comparable period.

In the field of Medicine we have seen the introduction of sulfanilamide in 1936. In the field of Surgery the remarkable improvements in thoracic surgery and the daring vascular surgery are awe-inspiring and of enormous benefit. The appearance almost annually of newer and less toxic sulfonamides and various antibiotics with broader spectrum have crowded in on us to such a degree that we, the medical profession recklessly prescribe them often in inadequate doses, causing the development of resistant strain of organisms and producing sensitivity of a severe type in certain individuals.

Three years ago this May, Dr. Hench introduced his very dramatic findings of the value of the substance now known as Cortisone in the treatment of rheumatoid arthritis, and since that time the therapeutic trial of ACTH and Cortisone has been extended to every field of medicine. The volume of data accumulated and published

¹ Papers presented on Tuesday afternoon, April 29, 1952, at the Annual Meeting, Medical and Chirurgical Faculty of Maryland. (Faculty Transactions, 1952.)

² Vice-President.

³ Associate Professor of Medicine, School of Medicine, The Johns Hopkins University.

is overwhelming and almost beyond the comprehension of the average physician. These two substances have been so publicized both in the medical and lay press that one might get the idea that we have reached the millenium and we have one substance that will cure all ills.

At a conference two years ago, I heard a word of caution used that might bear repeating, namely, that "these drugs ACTH and Cortisone are only cures in self-limited diseases and should be used only with great caution." It has been admitted that these two and similar substances are of tremendous accessory value in the treatment of a great variety of disease processes. However, we must understand something about the fundamental and potent effects of ACTH and Cortisone on the human being as a whole before we can use them properly. It would be nice to have Dr. Krantz talk about the pharmacological and physiological effects of ACTH and Cortisone.

DR. KRANTZ⁴: Mr. Chairman, Members of the Medical and Chirurgical Faculty and Guests. On Christmas day in 1914, E. C. Kendall, working at the Mayo Clinic, isolated thyroxin from thyroid glands. Twenty-one years later in 1935 this same biological chemist succeeded in isolating from the adrenal cortex what is now known as Kendall's Compound "E" or Cortisone. He obtained this substance in only milligram quantities.

It is very interesting to note how he happened to get any of it at all. It was through the interest of Oliver Kamm of Parke-Davis & Company, who supplied him with adrenal glands from which Kendall made first the impure adrenalin. This was then shipped back to Parke-Davis & Company, and they supplied the pure adrenalin to the medical profession. But it was the supplying of large amounts of the adrenal gland to Kendall by Oliver Kamm that made it possible for him to get milligram quantities of Cortisone.

⁴ Professor of Pharmacology, School of Medicine, The University of Maryland.

With this meagre amount of substance Kendall was able to show that rats, upon injection could be made resistant to strain, to poisons, to exposure to cold, etc. Owing to the paucity of supply no clinical tests on this substance were carried out.

In 1942 word came to this country through military sources that members of the Luftwaffe were injected with eleven ketosteroids in order to give them excessive resistance to stress and strain. The making of this Compound "E" of Kendall then became an emergency measure, and in 1946, shortly after the war was over, Kendall succeeded in synthesizing Cortisone. In 1948, Sarrett, of Merck & Company, went through the thirty-seven separate and distinct steps of synthesis and provided this compound in gram rather than in milligram quantities, in which heretofore it had only been available.

The development of ACTH follows a similar pattern. Dr. Lye at the University of California, working with very small quantities of pituitary glands, succeeded in getting ACTH in an active form from the anterior lobe of the pituitary body. Dr. Mott of the Armour Laboratory, following this laboratory procedure in 1948, got ACTH in such a form that it was made available to several clinics in the country, much of it being sent to Dr. George W. Thorn. We are indebted to the work of Dr. Thorn in first exploring its potentialities in the Peter Bent Brigham Hospital.

Today ACTH and Cortisone are available in quantity, and our consideration this afternoon will be some of their physiologic and pharmacologic responses, with special emphasis upon the theme of the afternoon, namely, the untoward effects elicited by these substances.

Figure 1 shows the development from a physiological standpoint of ACTH. The release of Cortisone is also shown. One observes first that at figure "1," neurogenic stimuli, the autonomic phase of the development and secretion of this substance is begun. This passes over to "2" in the diencephalon. This then passes down to "3," which is the adrenal medulla. The adrenal

medulla, stimulated by the splanchnic nerves, stimulates the secretion of adrenalin. Passing from "3" to "4," the anterior lobe of the pituitary body is stimulated and here ACTH is secreted from the basophilic and acidophilic cells of the

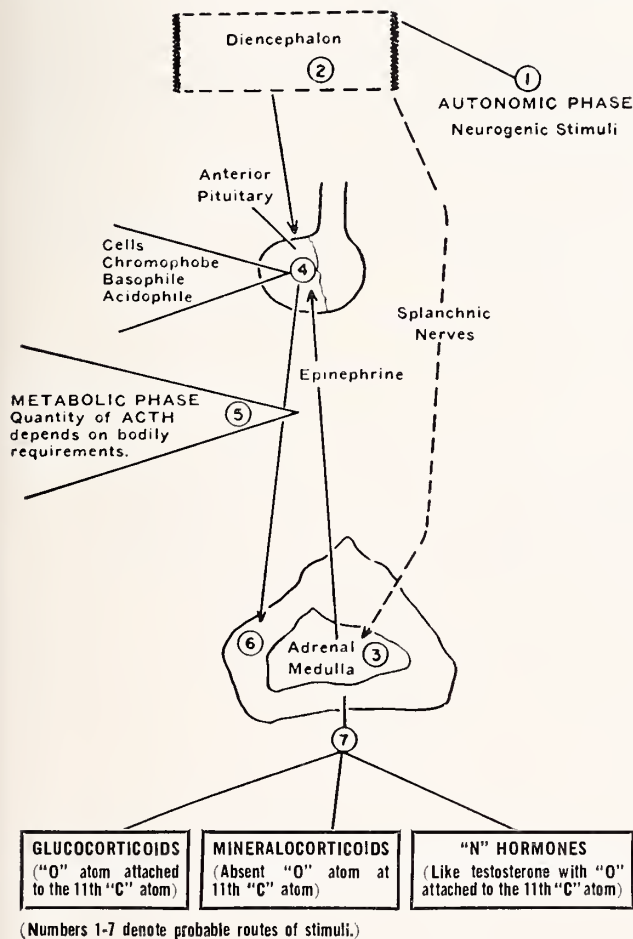


FIG. 1

(Derbes and Weiss, *Untoward Reactions of Cortisone and ACTH*, 1951)

pituitary anterior lobe. At "5" we enter into the so-called metabolic phase of ACTH, and the quantity of ACTH so released depends upon body requirements. The ACTH so released stimulates the adrenal cortex at "6," and the adrenal cortex at "7" releases into the circulation a series of so-called *corticoids*. The first type of corticoids shown contains an oxygen atom at position 11, the second type is the mineral corticoids, the third—the so-called "N" hormones.

Figure 2 shows these various steroids and the effects that they produce. The glucocorticoids include Kendall's Compound "E," which is Cortisone. 11-Dehydrocorticosterone is Kendall's Compound "A." Corticosterone is Kendall's Compound "B," and 17-hydroxycorticosterone is Kendall's Compound "F." In this series one has two compounds available for therapy, namely, Cortisone and hydroxycortisone, which is known as Cortone. The last-mentioned steroid has a localized action; it is used by injection directly into the joint which is affected.

Let us consider the effect of the glucocorticoids. They increase the exogenous conversion of carbohydrate to glycogen. They increase the blood sugar level and cause a mobilization and utilization of fat. They diminish the oxidation of available carbohydrate. They depress adrenal cortico tissue and the thymus. They cause the destruction of lymphocytes and eosinophils, they increase protein metabolism, they decrease protein anabolism, and they increase antihyaluronidase activity. The resistance of the organism to certain forms of stress and strain is increased. There is also an increase in sodium retention and an increase in urinary excretion of potassium.

If one observes the title of these particular steroids, namely, "glucocorticoids," this would lead one to believe that they affect only carbohydrate metabolism. A moment's glance at Figure 2 indicates they have a far greater effect than that and also affect electrolyte balance and protein metabolism.

The second classification of the corticoids obtained from the adrenal cortex is the mineralocorticoids. Desoxycorticosterone and 11-desoxycortisone, which is probably Reichstein's Compound "S," have the following actions: Urinary retention of sodium and chlorine, increase in plasma volume, increase in extracellular fluid volume, diminution in sodium and chlorine in perspiration, and increase in urinary excretion of potassium. One finds here that the action of the mineralocorticoids and the glucocorticoids overlap in a qualitative sense. Nevertheless the

activity on electrolyte balance, that is, the activity on potassium secretion and sodium retention, is about thirty times as great with this second class of corticoids as it is with the glucocorticoids.

The next class, the "N" hormones, are not of especial interest in the treatment of the diseases in which Cortisone and ACTH are used. One finds in this group adrenosterone, and possibly estrone and progesterone. The action in general

differ from Cortisone mainly in that its action is localized at the joint, and is therefore, as I have mentioned before, injected intraarticularly and is not used in the treatment of systemic diseases.

The data set forth in Figure 4 show the effect in a general way on various systems of the body which are affected by ACTH, Cortisone and other of these cortico hormones. Let us consider first the endocrine glands with ACTH. One finds

GLUCOCORTICOIDS	MINERALOCORTICOIDS	"N" HORMONES
Cortisone (Kendall's Comp. E) 11-Dehydrocorticosterone (Kendall's Comp. A) Corticosterone (Kendall's Comp. B) 17-Hydroxycorticosterone (Kendall's Comp. F)	Desoxycorticosterone 11-Desoxycortisone (Reichstein's Comp. S?)	Adrenosterone Estrone (?) Progesterone (?)
Actions: Gluconeogenesis ↑ Exogenous CHO to Glycogen ↑ Blood sugar level ↑ Mobilization and utilization of fat ↓ Oxidation of available CHO ↓ Adrenalcortical tissue and thymus Destruction of lymphocytes and eosinophiles ↑ Protein catabolism ↓ Protein anabolism ↑ Antihyaluronidase activity ↑ Resistance of organism to certain forms of stress ↑ Na retention ↑ Urinary excretion of potassium	Actions: Urinary retention of Na & Cl ↑ Plasma volume ↑ Extracellular fluid volume ↓ Na & Cl in perspiration ↑ Urinary excretion of potassium	Actions: Retention of Nitrogen Phosphorous Potassium Na Cl

(Derbes and Weiss, *Untoward Reactions of Cortisone and ACTH*, 1951)

FIG. 2

of these steroids is the retention of nitrogen, phosphorus, potassium, sodium and chlorine.

Figure 3 shows the chemical formulas of the two substances obtained from the adrenal cortex which are available in the treatment of the collagen diseases. One of these is Cortisone. One notes that it has an oxygen atom at position 11, and it was the thirty-seven step synthesis, that I mentioned in my introductory remarks required to get that oxygen atom at that special position in the steroid nucleus.

Now if one passes from the so-called Compound "E" of Kendall to Compound "F" of Kendall, one has hydrocortone, which has a hydroxyl group at position 11, and appears to

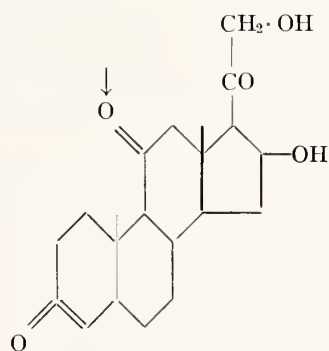
when ACTH is given the pituitary gland shows an increase in basophilic cells, and some of the chromophobic cells show stippling. One finds that the adrenal cortex is stimulated by the administration of ACTH. Its activity and even the tissue of the gland itself are depressed by the administration of Cortisone. The pancreas is affected by both ACTH and Cortisone. Each appears to be diabetogenic. As a matter of fact, in laboratory animals one can show that repeated injections of ACTH or Cortisone can produce hydropic degeneration of the beta cells of the islet tissue similar to the effects obtained by the administration of alloxan, which produces a so-called alloxan diabetes. The thyroid gland

is depressed, the action on the gonads appears to be capricious. In certain laboratory animals, with perfectly massive doses of either ACTH or Cortisone it can be shown that the testes undergo regression. However, clinically the activity does not appear to be marked.

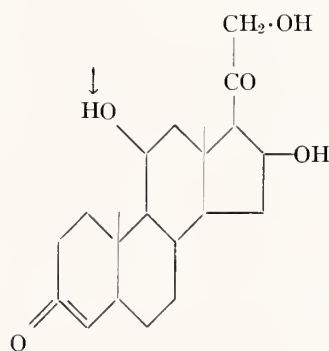
Regarding electrolyte balance, one finds that potassium, nitrogen, calcium and phosphorus show a negative balance under the effect of ACTH or Cortisone. Now let us discuss each one of these separately. The excretion of potassium in large quantities is frequently the cause of the muscular weakness, the fatigability and

Now the cardiovascular system, and first, let us consider blood pressure. In normotensive individuals there is little change in blood pressure from the administration of either ACTH or Cortisone. In those patients which are inclined to be hypertensive or who have definite primary hypertension, the blood pressure frequently tends to rise. Over a period of treatment lasting three or four months, one might expect in people with hypertension an increase in blood pressure of thirty over twenty millimeters.

Neither of these substances directly has an effect upon the heart. Nevertheless one may



Compound "E"
Cortisone
Oxygen at position 11



Compound "F"
HydroCortone
Hydroxyl at position 11

FIG. 3

possibly the collapse of the individual under Cortisone or ACTH treatment. The excretion of nitrogen is important owing to the excretion of an abundance of uric acid and other nitrogenous waste. This gives rise to the utilitarian value of ACTH in the treatment of gout. Calcium and phosphorus balance is negative. Excretion of calcium and phosphorus with a concomitant osteoporosis may lead to bone fracture. This of course is in its final analysis due to the fact that ACTH and Cortisone alike cause an excess excretion of the elements of bone, namely, phosphorus and calcium. Sodium and chlorine are retained. Sodium and chlorine retention gives rise to edema very frequently, ascites and anasarca. They put an extra strain on the heart and may precipitate congestive heart failure in a patient who is subject to the disease.

precipitate a cardiac collapse from excessive loss of potassium. One may put extra strain on the heart by the retention of sodium chloride, with the concomitant retention of fluid. These changes in the cardiac activity are manifested in the EKG and very frequently after prolonged treatment with either of the two substances one may find that there is an increase in the QR interval, a flattening of the "T" wave, and in many individuals a reversal of the "T" wave. The cholesterol content of the blood is elevated. Thyroid activity is depressed, oxygen consumption of the individual is diminished and the cholesterol content of the blood somewhat increased by the administration of either of these two substances. There would therefore be a tendency for the production of atheromatous plaques in the vessels, and arteriosclerosis ulti-

mately may be the outcome of prolonged administration of either of these two drugs.

The clotting time of blood is our next consideration. The clotting time of blood and the administration of ACTH is a very important problem, particularly in the post-coronary conditions. One finds that the whole matter in the literature is polemic. However, at the present time there are certain facts that seem to stand

1. Endocrine glands
 - a. Anterior pituitary
 - b. Adrenal cortex
 - c. Pancreas
 - d. Thyroid
 - e. Gonads
2. Electrolyte balance
 - a. K, N₂, Ca, P₄ negative
 - b. Na and Cl positive
3. Cardio-vascular system
 - a. Blood pressure
 - b. Heart
 - c. E.K.G.
 - d. Cholesterolemia
 - e. Clotting time
4. Infections
 - a. Diagnosis
 - b. Virulence and duration
5. Musculo-skeletal system
 - a. Muscle
 - b. Bone
6. Skin
7. Central nervous system
8. Gastrointestinal tract

FIG. 4. Effect of ACTH and cortisone on physiological systems and functions.

out in bold relief. For example, Cosgriff studied carefully 175 patients and measured the clotting time of blood under the administration of both ACTH and Cortisone. After prolonged periods of treatment with rather high dosage levels he found that eleven out of these 175 individuals manifested thrombo-embolic phenomena. Therefore must one bear in mind always that each of these substances appears to give rise to a more rapid clotting of the blood, and if they are to be given to people who have a history of coronary disease this should be taken into consideration.

Infections are very frequently masked by the administration of these agents. ACTH and Cortisone are antipyretics. What is more, they oftentime cause a diminution of the white cell count, followed by a rise in total white cell count. It is possible for the administration of these substances to mask an infection that is present in the patient. Now the virulence and duration of the infection is also affected by the administration of the drug. Tuberculosis, staphylococcal and streptococcal infections, influenza and other diseases which may be lying dormant may undergo an exacerbation when either of these two substances is administered. What is more, an infection which is already present may be worsened by the administration of ACTH or Cortisone.

Now with regard to the musculoskeletal system. I have already said that the muscle undergoes a serious metabolic injury when it loses too much potassium, and the cause of much of the muscular weakness and fatigue upon the administration of these agents appears to be due to muscle loss of potassium. One, of course, can combat this by administering to the patient, during the giving of ACTH or Cortisone, potassium chloride or some other potassium salt.

And now bone. We have already spoken of bone and the osteoporosis which results from the negative calcium and phosphorus balance. The possibility of spontaneous fractures has also been mentioned.

Let us consider the skin. A series of symptoms that occur very frequently upon the administration of ACTH or Cortisone are manifested in the skin,—acne vulgaris, hirsutism in different parts of the body, loss of hair in the scalp, the typical Cushing syndrome. One finds the buffalo distribution of fat under the skin, also that the skin very frequently may become very sensitive, and a very definite erythema may result from the administration of Cortisone or ACTH.

Next the central nervous system. Hench, in his first paper on the use of Cortisone in the treatment of rheumatoid arthritis, noted that his

first patients experienced euphoria, buoyancy and overconfidence. Volubility, garrulousness and a desire to do many things that they had never done before were often encountered. Very frequently this is followed by a state of depression; schizoid episodes are sometimes noticed and anxiety states are very frequently produced. One is convinced that many personality changes may be produced by the administration of either ACTH or Cortisone.

As the cardiac changes can be observed in the electrocardiogram, one further asks, can the changes in the brain be registered in the electroencephalogram? Yes, it is possible. After the continued administration of either ACTH or Cortisone one finds a disappearance of the regular alpha rhythm. One also can find spiking, similar to that which occurs in epileptic attacks. Convulsions and coma may occur after the prolonged administration of ACTH and Cortisone.

The last point to discuss is the administration of these drugs with regard to the gastrointestinal tract. It appears from extensive study that these drugs in many individuals give rise to nausea, vomiting and epigastric distress. If the patient has also ulcer diathesis an active ulcer may result. Many clinicians have estimated that as many as seven per cent of the individuals to whom ACTH or Cortisone is administered for long periods of time will show erosion of the duodenum or frank ulceration. Therefore active peptic ulcer is certainly a contraindication with regard to the administration of these substances.

In closing this discussion one cannot help but be impressed by the fact that if an oxygen atom is put in the 11th position of this nucleus (figure 3) profound changes can be brought about in the human body affecting nearly every system, every cell of the body. One is reminded of what the Psalmist said: "We are fearfully and wonderfully made." Thank you.

DR. WARDE B. ALLAN: Thank you very much, Dr. Krantz, for what I can really say with enthusiasm is an excellent summary of a very

complicated situation and put into language that I can understand, and I hope many of you are with me in that regard.

DR. WARDE B. ALLAN, *Moderator*: We will now call upon Dr. Harvey to recount some of his clinical experiences with these two substances.

DR. A. MCGEEH HARVEY⁵: Mr. Chairman, Members of the Faculty and Guests, when one listens to a description of the manifold physiological effects which take place following the administration of these hormones, as has just been very nicely elucidated by Dr. Krantz, one would get the impression that any patient who receives either Cortisone or ACTH is somewhat in the position of the one-horse shay; the physician might expect him to fall completely apart, but fortunately that is not the case. Most of these effects can be controlled without abolishing the desirable therapeutic effect that one is striving for in the average patient without much difficulty and with a very simple set of rules.

Most of the difficulties that Dr. Krantz has outlined arise from either failure to observe these simple rules or, in some patients who are receiving very large doses of either ACTH or Cortisone and over very long periods of time.

Now I think it important to remember one thing before we start the discussion of what the practical aspects are in treating patients as far as these physiological effects are concerned, and to get certain basic concepts clear. First of all except in a very few instances what we are actually doing with these hormones in the patient is quite different from what we are used to doing with most other hormonal substances. Now in a situation where you have a patient with myxedema, and you give that patient thyroid hormone you are actually substituting the hormone that the body itself is no longer able to elaborate. In certain instances that is what one does with ACTH or Cortisone. For instance, in the patient

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with anterior pituitary insufficiency post-operative or spontaneously developing, one is actually with ACTH replacing the ACTH that the patient can no longer elaborate. In a patient who has Addison's disease, or in a patient who has had a bilateral adrenalectomy for hypertension or cancer, the Cortisone that one administers to that patient is substituting for the Cortisone that that patient through his own pituitary adrenal system can no longer elaborate. But in most instances where we use ACTH and Cortisone, it is not substitution therapy. We are deliberately increasing the level of adrenal cortical activity. In other words, we are deliberately trying to produce certain of the things which Dr. Krantz has outlined and what we are after in order to get the effective result that we want is to avoid the untoward effects from this physiological excess activity which produces these various things that Dr. Krantz has outlined. We want to get our therapeutic effect and at the same time minimize the dangers from the overstimulation which we are deliberately producing, so that we are not dealing here with toxic effects of these hormones. Here we are deliberately raising the level of certain physiological activities of the patient, by use of hormones which the patient himself in most instances is capable of producing at a certain level.

Now let us recall for a moment the fundamental difference between ACTH and Cortisone. It is important to remember that with Cortisone therapy one is directly raising the level of the circulating adrenal hormone; that is the circulating level of the 11 oxysteroid that he pointed out to you is the compound which produces the therapeutic effect.

Now when we raise that level, we do certain things to the patient's own pituitary adrenal system. When you raise the level of circulating 11 oxysteroid by administering Cortisone or hydro-Cortisone which is Compound "F," the patient's own pituitary activity is suppressed which means in turn that the patient's own adrenal is no longer getting the normal stimulus from the pitui-

tary so that the patient's own adrenal actually will decrease in size and cease to put out its normal amount of hormone. So that you are producing a depression of the patient's own pituitary adrenal system.

Now with ACTH you are doing quite a different thing. You are in all probability suppressing the activity of the patient's own pituitary but if the ACTH is given for a very long period of time, you are actually causing his own adrenal to enlarge; the diametric opposite situation to what you have with Cortisone. Not only are you causing it to enlarge but that adrenal will put out the whole spectrum of adrenal hormones, the glucocorticoids, the mineralo corticoids and the androgenic substances, so that there you are raising the level in the body of the whole spectrum of adrenal hormones with ACTH, whereas with Cortisone you are administering only the glucocorticoid, the 11 oxy-hormone and probably are to some extent suppressing the output of the other two types of hormone.

Now first of all Dr. Krantz pointed out to you that the administration of ACTH and Cortisone has a very definite effect on other glands of internal secretion. Now that is a very important point because I think that many of us do not stop to realize when we administer these substances it is not like determining the level of sulfonamide in blood and knowing that that is the single factor that is changing. When you give one of these hormones it has an effect on the patient's own pituitary, the patient's own adrenal and it completely changes the whole pattern of his total endocrine function.

Now when one realizes that, it is very simple to see why thyroid function is affected because the anterior pituitary puts out as you know, a thyroid-stimulating hormone and when the patient's own pituitary is suppressed the patient's own pituitary puts out less of that thyroid-stimulating hormone. So that if you give ACTH or Cortisone long enough you can detect depression of thyroid function although in a very large experience, we have yet to find that

to be a clinically significant finding. It has been reported by others but it has not been a very important situation in our experience.

Also as you know and Dr. Krantz has pointed out, these substances do have a diabetogenic effect. They will raise the blood sugar if they are given in sufficient amount for a sufficient length of time and particularly in patients who have pre-existing diabetes or the anlage of diabetes. Gonadal function may be depressed but that again is not a very serious problem from the clinical point of view.

Now perhaps the most important effect of ACTH and Cortisone from the practical point of view is its effect on electrolyte metabolism, the retention of sodium, and the stimulation of loss of potassium. Those are the two most practical effects that we have to deal with, and as I will tell you later in giving you some figures on our experience with the detection of these abnormal physiological effects in patients, we'll see that these are among the most important ones. It is quite clear from the experience in patients, that these problems can be very easily handled if one understands the problem at hand and follows certain very simple rules for avoiding difficulty.

First of all, retention of sodium. You all know and Dr. Krantz has outlined the potential effects of excessive retention of sodium. One has no different problem here than what one sees in patients who go into congestive heart failure. You are creating that sort of situation really in the normal individual. The patient retains sodium, his blood volume increases, his extracellular volume increases and if it goes to a great enough extent he will become edematous, congestion may develop in the cardiovascular system with all the clinical manifestations of cardiac insufficiency.

Now in the patient who has normal kidneys, one can with restriction of sodium to a sufficient degree avoid the development of edema or avoid any really serious complications from this physiological effect of these two substances.

We have had no difficulty with patients gaining weight due to retention of water or to the development of overt edema or development of heart failure since early in the game, when we have routinely restricted the intake of sodium to four grams or less, no matter how much ACTH or Cortisone the patients were getting or for how long a period. We have routinely done it to avoid difficulty and that is a very successful means of doing it and a very simple one if you follow it rigidly in patients who are receiving these hormones.

Now equally important is to follow the simple rule of taking care of the expected loss in potassium and that is very simple to do. One can give the patient a potassium salt to take by mouth while he is taking ACTH and Cortisone and again, if that is rigidly followed in every patient there will be no difficulty from low potassium syndrome. We routinely give patients from three to twelve grams of potassium chloride by mouth each day while they are taking these substances, the amount depending on how long they are going to be treated and what dosage level they are going to receive. If one rigidly follows the program of having these patients limit their salt intake and add potassium to their program, serious difficulty from the effects of either sodium retention or potassium excretion can be avoided.

There are circumstances, however, when more drastic measures must be taken and when difficulties may arise. In the patient who already has a situation where he is retaining sodium as in a patient with renal disease or in a patient with cardiac insufficiency and inability to excrete sodium properly, then one obviously has a much more dangerous situation. Under those circumstances I do not think that these hormones should be given unless the indication is so imperative that one has to overlook the dangers involved.

Under those circumstances even when the patient has pre-existing hypertension or has had a pre-existing heart disease with evidences of

cardiac insufficiency or when the patient has already had some kidney difficulty which has impaired sodium excretion, we have seen situations in which it was still a matter of life and death as to whether the hormones were given. We have proceeded without any serious difficulties in those instances by very rigid restriction of sodium down to an intake of fifty milligrams a day and added potassium. Also one other thing and that is to remember the difference between ACTH and Cortisone.

As Dr. Krantz has pointed out, the glucocorticoids which Compound "E" and "F" are examples of, do not stimulate the adrenal. They do not have as potent a sodium retaining effect as does desoxycorticosterone which comes from the adrenal and which you will have the adrenal excrete if you give the patient ACTH under situations where you want less sodium retention. Then it is better to use Cortisone I think, than to use ACTH.

Now if you use Cortisone by mouth the duration of its effect is relatively short, so that you are producing intermittent elevation in the level of adrenal activity and under those circumstances it is possible in most instances to get the therapeutic effect that you desire without the dangerous level of sodium retention, provided you also very rigidly restrict the sodium intake and by all means add potassium to the patient's therapy.

Now potassium deficiency which may develop during the use of these hormones can be somewhat difficult to recognize if one is not aware of it and suspicious of the possibility. As you know the lowering of the serum potassium leads to muscular weakness, to loss of the deep reflexes, has an effect on the cardiac muscle and the patient will develop cardiac collapse. During that situation the patient may have abdominal distention. They may complain of cramps and pain in the abdomen and it may in many respects simulate an abdominal emergency, so that when one sees those symptoms develop in a patient receiving ACTH and Cortisone, it is wise before

calling the surgeon to take an electrocardiogram, to test the deep reflexes and try to determine the presence of potassium deficiency and take proper steps to alleviate it and see if that does not, as it always will when enough potassium is administered, cause a prompt reversal in the difficulties.

Under circumstances when one has a picture that looks as though it may represent an abdominal emergency situation requiring surgery when the patient is under ACTH or Cortisone, as Dr. Krantz has pointed out, another confusing element may be present and that is the leukocytosis which always develops in patients receiving adrenal stimulation from ACTH, or who have received any sizeable amount of Cortisone.

The effects on blood pressure also stem largely from this problem of sodium retention. They have occurred just as frequently in patients who were normotensive to begin with as those who were hypertensive. In fact about half the patients we have treated who have been hypertensive to start with have shown some drop in blood pressure during treatment. The danger, of course, in the presence of hypertension is again in those patients who have already had symptoms of heart failure or who have renal disease and who cannot excrete sodium as well as the normal individual. It is in those two situations that the real danger exists.

Now one other problem in relation to the cardiovascular system which Dr. Krantz has touched on and has pointed out to you as a somewhat controversial subject, that is, just what ACTH and Cortisone do to the blood-clotting mechanism. There has been as he has said, a great deal of dispute on this subject. Some people have said the clotting time is prolonged; others have said it is reduced; some have said prothrombin time is prolonged, others have said it is reduced, but I think the situation is really that they do not have any very important practical effect on blood clotting mechanisms in the average doses in which they are used clinically. We have seen only a very few

situations in which phlebitis or thrombophlebitis or any other type of thrombosis has developed in patients receiving these substances, and in almost every instance that has been in patients who had some type of vascular disease which already created a situation which predisposed to the development of clotting in vessels. That is, some disease involving the arterial walls as in lupus erythematosus, or periarteritis nodosa or in people who already had a very serious chronic debilitating disease. From a practical point of view I think one has to be cautious in terms of these complications and to keep their possibility in mind just as one does in patients who are not receiving ACTH or Cortisone.

Now what are the practical problems in relation to infections? Well, as Dr. Krantz again has pointed out, in almost any patient having fever, if you raise the level of his adrenal activity with either ACTH or Cortisone there will probably be a drop in his temperature, in most instances to normal levels and in many instances, if your level of stimulation is high to even sub-normal levels.

These substances have a very strong stimulating effect on the bone marrow. They'll cause in almost every instance a leukocytosis and the appearance of many young forms in the peripheral blood. That is a physiological effect of overstimulation so that one is almost always confronted with the situation in which the patient has a leukocytosis and where the patient's constitutional reaction is depressed in terms of his ability to develop a fever or to show changes in pulse rate, or to localize pain well. One has a situation in which the development of an infection may be masked.

There is one other situation which Dr. Krantz didn't touch on in any detail but which may be very important in this sphere and that is, in patients receiving ACTH and Cortisone, if the amounts are reasonably large as necessitated in some instances, there may be a depression of wound healing. Now the reason for that is a depression in the ability of the body to form

granulation tissue. Epithelialization can occur perfectly alright but the body cannot lay down granulation tissues satisfactorily as in a person who has normal adrenal function. That is an observation which has long been recognized in patients with Cushing's disease, and if you have an infection under these circumstances which starts out as a local infection, the body may not be able to keep it local and to wall it off. And so the infection may spread and be a generalized infection when ordinarily it would be a local affair.

There is a great deal yet to be learned about the situation in regard to infections. There is no question but that during administration of these hormones one may see the development of a bloodstream infection. We have seen that in about five per cent of the cases, again mostly in individuals with diseases in which that situation might be expected to arise anyway—that is in patients with leukemia; other types of blood dyscrasia, with a type of disease in which infection already tends to develop such as in patients with various types of collagen vascular disease. So again it is very difficult to tell many times how much is the disease and the lowered resistance of the patient and the inability of the patient to call on his normal means of combating infection and how much of it is due to ACTH and Cortisone. One must be aware of that possibility, and again attempts should be made to clear up any infection before these substances are used and their use should be avoided, I think, in patients who already have infection, again unless the indication is very great for their usage.

Now there is, as you probably have seen in the literature, a growing effort on the part of certain people to use these hormones in patients with overwhelming infections. This stems from the fact as we have already pointed out that the constitutional reaction to severe infections is suppressed—that is, the fever goes down, the patient feels much better, his appetite improves and he looks generally relatively normal and

feels well even in the presence of an overwhelming infection. We have seen that in patients with generalized peritonitis.

Now, what is the mechanism by which ACTH produces this blocking of the body's normal recognition of the presence of an infection and the body's usual response to that infection in terms of fever and malaise and chills and other changes which come about under those circumstances? Well, no one knows that, but it looks as though it occurs at the cellular level, that the body does something to prevent the action of the bacterial toxins on the cells of the body either by blocking their access to the cells or by protecting enzyme systems in those cells to the effect of the toxin or possibly by other mechanisms. In any event it seems to take place, and there have been many patients treated now with overwhelming infections and the results are very difficult to interpret. It has been done on the basis that if one uses sufficient antibiotics, that by eliminating the usual toxic effects of the infection—no one knows exactly what they mean or what their purpose is really—but that one may save the patient if those effects can be blocked and without doing any harm if antibiotics are maintained.

For instance, Dr. Kinsell has now treated a good many children who have come in with a perforated appendix, seriously ill in coma and the terminal stages of generalized peritonitis, by giving antibiotics plus ACTH or Cortisone, and he feels very definitely that it has been a life-saving measure in many of those situations. He has found that within a few hours their clinical condition improves rather dramatically, and if the antibiotics are then continued and ACTH or Cortisone stopped, that the patient's condition becomes more critical again. So that he feels that the situation seems to be a fairly definite one in terms of the advantages of using antibiotics and Cortisone in those desperate situations.

I'd like to caution you however about it. We do not yet know whether ACTH or Cortisone

in any way interferes with the effect of antibiotics, and we also, as I pointed out, do not know what we may be doing when we suppress the usual reactions of the body to infection. Nevertheless that is the situation at the moment in which it looks as though in certain of those critical situations where antibiotics alone are obviously not going to handle the problem, that ACTH or Cortisone have been tried.

Now you've probably heard a good deal about the problem of ACTH and Cortisone in patients with tuberculosis. That again has many aspects to it. The effects are varied, depending on the species of tubercle bacillus and the host in which the infection has occurred. Some investigators have said there was no effect; others have said there was a very deleterious effect and under the influence of these substances the tuberculous infection may become very widespread. There are no final answers. All I have to say is that I think at the present time that in general the use of ACTH or Cortisone in patients with tuberculosis should be avoided, unless it becomes a life-and-death matter.

One other important problem is in relation to the apparent deleterious effect of ACTH and Cortisone in certain infections. It is the problem that the general practitioner runs into in the patient who comes in with a fever and in which the cause of that fever is not clear. I am speaking particularly of two situations where one must use great caution in administering these drugs. It has been shown experimentally that the course of poliomyelitis is made very much worse by raising the level of adrenal cortical function. I think you are all well aware that it has been recognized for some time that poliomyelitis was always a much more serious disease when it developed in the pregnant woman who has already raised her own level of adrenal function. Experimentally it has now been shown the disease is much more fulminating in animals who are given ACTH and Cortisone. Do not use these substances until the diagnosis is clear and particularly when it conceivably could be

poliomyelitis. At times another very difficult disease to diagnose in the child is rheumatic fever. There is no question that one can suppress the active manifestations of rheumatic fever (fever and arthritis), with these substances. It is still not clear as to what the eventual effect is going to be in relation to the tissue changes that are taking place in the heart itself. We do not know at what level they have to be treated to prevent the progression of lesions in those areas or whether it can be done. That is all under study at the present time, but there is no rush about giving ACTH and Cortisone to a patient with rheumatic fever. At times as you know, it may be very difficult to make that diagnosis. Under those circumstances if the child has some other type of infection, one may get into a serious situation by giving these hormones when the diagnosis is not clear and when it is possibly some type of infection.

Now the problem in relationship to those complications involving the skin and mucous membranes is clinically from a practical point of view mainly of cosmetic interest. Hirsutism rarely develops unless very excessive amounts of these hormones are given over a long period of time. It rarely is a problem except in the darkhaired woman whose facial hair has always been not visible and becomes dark and excessive under use of these hormones; that most often will regress and is something to watch under those circumstances but it is not a very serious problem. Very occasionally as has been known previously in patients with Cushing's disease, all the hair from the scalp may be lost and in our experience that has occurred in a very small group of patients. Some of them already had some reason for losing their hair in terms of the fact that they had an atopic type of dermatitis.

Acne may appear but it is usually a transient phenomenon and is in our experience infrequently seen except in those who have to have high dosage therapy for a long period of time. Occasionally, particularly with ACTH and again in the dark-skinned individual, one may see some

deepening of pigmentation which again may be of cosmetic difficulty for the patient but otherwise has no serious imports and again will decrease when the drugs are stopped or the dosage materially lowered.

Now we have referred briefly to the problem of wound healing. At ordinary therapeutic levels I don't believe that is a serious problem. We operate on patients who are receiving these hormones. However, if it is going to be a major operation or where wound-healing is an important problem, we try and keep the level of adrenal hormone administration low and eliminate it if possible soon after the operative time so we can be certain that healing will not be interfered with.

To give you an example of the situation you may run into, we have a patient who is being operated on today who has a hemolytic type of anemia. Her anemia responds very promptly to Cortisone administration. Hematocrit comes right up to normal levels and stays there, but it takes about 300 milligrams of Cortisone a day to suppress the reaction. When you drop her to 250 milligrams, the hematocrit begins to drop pretty rapidly. Obviously she can't stay forever on three hundred milligrams of Cortisone a day. We are going to try and relieve her situation by removing the spleen. Now she is going to the operating table taking 300 milligrams of oral Cortisone a day, but as soon as her spleen is out we feel that the problem will be helped in all likelihood. In any event we have control of the situation because oral Cortisone is excreted very rapidly. We can reduce this excess function of her adrenal very promptly. We propose to do so fairly rapidly in the post-operative period so that we will not get into the problem of retardation of wound healing.

I have little to add to what Dr. Krantz has already said about central nervous system difficulties. One must recognize the possibility of the development of serious mental reaction under large dose-long term usage of these hormones and recognize the fact that in most peoples' experi-

ence, it has developed in situations where the patient already had a serious emotional problem to which he was pretty well adjusted. However, when you disturb his physiological environment, suddenly his adjustment breaks down and you are faced with a serious situation in terms of very violent psychotic reaction. This usually will subside, although if the patient already has had an unrecognized or fairly well compensated psychological difficulty, one may find that recovery is not so easy to bring about. It is important to try and recognize the existence of that situation before treating patients and not to treat them unless absolutely necessary when they have had or are having emotional difficulties.

Finally, the gastrointestinal tract. ACTH supposedly does several things to the gastrointestinal tract. It increases the secretion of hydrochloric acid in the stomach. It increases the secretion of pepsin and also affects protein metabolism by the stimulation of excessive protein break down. One has a series of events which may be very deleterious in terms of the patient with a peptic ulcer. However, from the experience thus far, it is very difficult to know whether complications from peptic ulcer develop more often in these patients than they would if they were not treated and had the same diseases. Nevertheless ulceration seems to have been aggravated in a few instances during the course of treatment. That can usually be handled quite well if it is really necessary to continue treatment by putting the patient on a regular ulcer regime with diet and proper anti-acid therapy.

In our experience with about five hundred patients, we have had no perforation of a peptic ulcer. Nearly three per cent of the patients have developed ulcer symptoms, many of whom already have had an ulcer. In most instances when it was necessary to continue therapy there has been satisfactory response. Perforations have been described and again one must remember that the usual reaction of the body to the peritonitis which develops may be suppressed, the

patient may have a perforation with a general peritonitis, no fever, no abdominal rigidity, no change in pulse rate and very little pain. So that the perforation may sit there and peritonitis may proceed for several days before one recognizes what has happened. It is very important to be on the alert for this complication and again to take the proper precautions in patients who have had ulcer symptoms, and again not to treat them unless it is essential to do so.

Gastrointestinal hemorrhage of a massive type may occasionally develop, usually in situations where there is a pre-existing reason, the patient having a previous ulcer or some disease involving the gastrointestinal tract. That has happened very infrequently in our experience but again it is a possibility which must be watched for in patients who are receiving rather intensive treatment.

Getting back for just a moment to the problem of bleeding in contrast to the problem of thrombosis, in most instances where the patient already has a hemorrhagic tendency even though the blood abnormality associated with that hemorrhagic tendency may not be changed by therapy, in our experience in most instances the bleeding tendency has been suppressed. In a patient with a thrombocytopenic purpura the bleeding may subside to a large extent before there is actually any change in the platelet count. Why that occurs no one knows for certain. It has been suggested that these substances do alter capillary permeability and may in that way affect the tendency to bleed.

In closing I would just like to give you one or two words about my philosophy since no one has said anything about the indications for the use of these substances and that is a very large field. First of all we have no evidence that any disease can be cured by the use of these substances. One can alter the activity of the disease but one cannot cure any disease. That is the first important thing.

Remembering that fact, it is always a help

to classify the types of disease that one is called upon to consider treating with these substances, into four major categories. (1) those diseases in which there is a pituitary or adrenal cortical insufficiency. That is a simple matter, there is no question about their usage there, that is substitution therapy just like giving a thyroid extract to a patient with myxedema. (2) we have a certain group of diseases which are self-limited, either self-limited or in which the cause of the disease can be removed. Now there the classical examples are sensitivity reactions to various drugs such as penicillin or horse serum where one can use high dosages over a short period of time, very rapidly relieve the discomfort of the patient, remove the cause of the disease so that one doesn't have to worry about the untoward effects in that situation. Secondly, another example of a self-limited disease is sympathetic ophthalmia where the patient apparently becomes sensitized to his own uveal tract pigment. That disease eventually burns itself out, but in the process of doing so the inflammatory reaction which it sets up usually damages the eye to such an extent that the patient either loses a large portion or all of his vision in both eyes.

One can maintain a suppression of that inflammatory reaction with ACTH or Cortisone during the life period of the activity of that disease and preserve the patient's sight so that certainly one is going to use it in such circumstance. Then (3) those chronic diseases which in most instances do not endanger life but do cause serious discomfort and limitations of the patient's activity. I think that one must consider the use of these hormones in that type of disease when other and simpler measures of treatment have been without avail. For instance the patient with chronic intractable asthma who has not responded to other measures of treat-

ment, may find in many instances with perfectly safe dosages over a long period of time sufficient relief, to radically change his whole life program.

In the last (4) category are those diseases, either chronic or acute which, if the activity is not suppressed we know will in a vast majority of instances be fatal. In such a situation I think that one is justified in using enough of these hormones to keep the disease under control, even at considerable risk. Periarthritis nodosa is an example and, disseminated lupus erythematosus is another. Now of course in that category fall the usage of these hormones for increasing the comfort of a patient at times, having a fatal disease. At times the patient with a metastatic disseminated neoplasm may have his fever suppressed. A poor appetite may be stimulated. He may develop a sense of euphoria and well-being. Often it is a much more satisfactory type of symptomatic therapy than the use of large doses of narcotic or other means to try and make patients comfortable.

In closing I think that if one understands the basic action of these hormones, if one follows the simple rules in each case; if one recognizes the situation in which harmful reactions are apt to occur; if one recognizes also the fact that when considering long-term therapy that there may be subtle effects of these hormones still not understood, and if one takes those facts and tries to balance them against the seriousness of the disease and the need for adrenal therapy, I think one can in most instances formulate a fairly sensible program both for the comfort and help of the patient and to the advantage of the physician.

DR. WARDE B. ALLAN: Thank you for an illuminating discussion of a vast clinical experience with ACTH and Cortisone.

QUESTION AND ANSWER PERIOD

Q.: How does one decide whether to use ACTH or Cortisone?

DR. HARVEY: That depends on a good many facts. I don't think we have all the information on which to base a completely documented answer to such a question. In general I think if one is dealing with a disease which requires a fairly high level of adrenal activity to bring about suppression of activity, that if possible, ACTH should be used. That has been our general experience and we feel safer under those circumstances because if the patient for some reason has to stop therapy, you do not face nearly the danger from sudden adrenal insufficiency as you do if you withdraw a large dose of oral Cortisone particularly rather suddenly, which is a dangerous thing to do. We have a good many patients with chronic asthma, who have been taking oral Cortisone which is obviously much more convenient to do over long periods of time and at sufficiently low dosage levels, around 50 milligrams a day. Such dosage does not seem from ketosteroid studies and observations, to have seriously suppressed the patient's own adrenal activity, and we have yet seen no difficulties under those circumstances but I think that one must still proceed with caution in long-term therapy and particularly if one has to exceed 75 milligrams of Cortisone a day or probably twenty to thirty milligrams of ACTH a day. Now there is one important thing to remember and that is this whole problem of ACTH intramuscularly. In the early period Armour was making a relatively unpurified material which had only an activity of about one unit per milligram. That substance and its impurities apparently led to a situation when it was placed in muscle, whereby there was some actual destruction of the ACTH. That is probably the reason why there was such variation from patient to patient in the amount of ACTH required intramuscularly to get the proper therapeutic response for which one was looking. Dr. Astwood recently, by absorbing the pituitary

material on oxidized cellulose, has been able to concentrate it to a point where it contains about eighty units per milligram. That, of course, is a much more purified material and thus far it seems to be free from this destructive activity that goes on in muscle. Apparently it has something to do with the impurity of the material and so far that has not been seen. Theoretically there is evidence already obtained, to suggest that one will be able to obtain with the ACTH gel, just as good adrenal stimulation over a twenty-four hour period as one can obtain with intravenous ACTH in unit per unit.

Q.: How about diet in the patient on ACTH or Cortisone?

DR. HARVEY: If the patient has any tendency to diabetes at all or has diabetes even in mild form or even in the normal individual, the following type of diet would seem to be indicated, e. g., a high protein, preferably 150 to 200 grams of protein a day because of the tendency for increased protein breakdown and secondly because of the fact that these hormones stimulate gluconeogenesis and, as you say, increase the appetite and the patients eat more carbohydrate. They probably should have some limitation of carbohydrate in their diet and perhaps some increase in the amount of fat because these compounds are not ketogenic in the ordinary patient. There is some evidence—it is still pretty slim—that under those circumstances one may actually get a better therapeutic effect than if the patient is on a very high carbohydrate-low fat diet.

Q.: I'd like to ask Dr. Harvey how he feels about the use of ACTH or Cortisone in either virus hepatitis or cirrhosis?

DR. HARVEY: In patients with cirrhosis, particularly patients who have advanced cirrhosis or in cholemia, there is some type of toxic reaction the cause of which is not clearly known, and why it happens no one quite knows, but in

that situation if you give ACTH or Cortisone in sufficient amounts, you may wake the patient out of his coma and stimulate his appetite. Clinically, he may look a great deal better. As far as I know, there is no real evidence that it is going to change specifically in any way, the outlook of his cirrhosis other than perhaps to improve his appetite and make it easier for you to sort of get the diet into him that you want him to have.

Again in a patient with viral hepatitis with fever, you get the general masking of constitutional reactions. If there is an inflammatory reaction in the liver, we know that ACTH will suppress a variety of types of inflammatory reaction, and so it may be of temporary benefit. There is some speculation that perhaps with the combination of ACTH and some type of antibiotic, one may be able to get the antibiotic into the cell and that is something to explore in terms of the treatment of virus infection or infections of other types in which the organisms live inside the cell as in rickettsial infections but those points are just at a superficial level of knowledge at the present time.

Q.: How much specialized laboratory work does the practitioner have to do on patients getting these hormones?

DR. HARVEY: In the hospital where we are studying these patients particularly, we are trying to get as much data as possible so that

we can translate it into answers just as the ones you want. That is the sort of function we try to serve in the introduction of a new drug like this into medical practice. I may say that if you follow those simple rules and if you take the trouble to find out whether your patient has got any renal disease or any situation that is going to lead him to retain sodium in an abnormal fashion, and if you are not going to treat him over excessive periods of time with very large doses, then I think you are perfectly safe if you insist and see that the patient follows your advice of restricting sodium and if you give him added potassium. If you follow the patient's weight and follow the patient's blood pressure and see the patient often enough to pick up any clinical evidences of difficulty, they are going to show up clinically and you don't have to have blood sodium determination. As far as potassium difficulties are concerned, it is pretty simple in most instances if the situation demands it to get an electrocardiogram. That will tell you just as much about potassium level in most instances as blood potassium determination will.

DR. WARDE B. ALLAN: Are there any other questions? If not, we want to thank all the participants from the floor and also the two main speakers and we will now call the meeting adjourned.

NOTICE

The Council on National Emergency Medical Service of the American Medical Association has, during the past several months, sponsored a series of articles on the medical aspects of civil defense which has appeared in the *Journal of the American Medical Association*.

These articles have now been reproduced in booklet form. It appears from the large number of requests for the booklet that the articles are of genuine interest to the medical profession and the general public. The booklet sells for 25¢ a single copy, and 20¢ per copy for orders of 100 or more.

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MUSHROOM DERMATITIS

H. HANFORD HOPKINS, M.D.*

Every physician is, or thinks he is familiar with the symptoms and signs of poison ivy dermatitis, and "athlete's foot." He makes the diagnosis and prescribes usually without second thought. Nevertheless it is well known to those of us who have a singular interest in diseases of the skin that many examples of contact dermatitis are mistakenly diagnosed "poison ivy," or "ringworm." This is particularly true when the offending blisters present themselves on the hands or feet. The reason for this common mistake of course is that all cases of contact dermatitis look very much alike. Cases differ largely in the distribution, contour and pattern of the lesions. For example poison ivy begins on exposed parts, and the original lesions are in streaks or linear scratch marks. On the other hand nail polish dermatitis is nearly always confined to the eyelids or neck where the polish is inadvertently transferred as the result of a habit of rubbing, or stroking these parts with the painted finger nails. Often it is only when the supposed poison ivy or ringworm fails to disappear, that suspicion is aroused on the part of patient or physician that some other noxious agent may be responsible for the trouble.

The possible causal agents of contact dermatitis are almost unlimited, and new causes are constantly being reported. Most recently colored toilet paper has been incriminated, and such diverse substances as cocobolo wood, bubble gum, hair lacquer and match flaps might be mentioned as examples. Since irrespective of origin, the gross features of contact dermatitis are or can be so similar in all cases, great emphasis must be placed upon the distribution of the eruption in arriving at a correct diagnosis in any one particular case. The history, or present illness, is likewise very important, but can at times be misleading.

* Baltimore, Md.

The purpose of this writing is to point up the above characteristics of contact dermatitis, in the following report of what I believe is a newly found and rather novel cause for contact dermatitis.

CASE REPORT

E. A. W., a healthy white man of forty, complained on March 11th, 1952, of an itching eruption on his hands and eyelids. For about one year he had been working in a mushroom plant where mushrooms are grown commercially. His job consisted of working the beds, and picking and packing the mushrooms in baskets. The manner in which he used his hands to pick and pack proved to be the key to the correct diagnosis, in spite of, as will be shown, a very misleading history.

Four months prior to the first examination he had picked mushrooms in a room which had been heavily and profusely dusted with an insecticide powder said to contain a nicotine compound. Four days after this exposure, blisters appeared on the pads of the fingers and thumb of the left hand, which he invariably used to pluck the mushrooms, and on the pad of the right thumb, upon which impinged the cutting edge of a short knife used to cut off the root of each mushroom before placing it in a basket. It was obvious that the eruption appeared first on those skin surfaces which were habitually most intimately exposed to mushroom or some extraneous coating on the mushrooms. The eruption persisted and in a few days the eyelids became swollen and inflamed. The patient, according to his subsequent story, was convinced that the condition was caused by exposure to the insecticide. He continued to work, but in two weeks was forced to stop because of the severity of the inflammation on his hands and eyelids. A physician who

saw him at this time told him he had "ringworm," and recommended local treatment. At the expiration of two more weeks, he had greatly improved, only to relapse into his former state after returning to work. In spite of local treatment the dermatitis persisted with partial remissions and exacerbations until first seen on March 11th.

On that date the patient presented a severe vesiculo-squamous dermatitis of all the finger pads of the left hand, and the thumb pads of both hands. The eyelids were swollen, erythematous and scaly. The history and distribution of the eruption immediately indicated that it was

caused by contact with mushroom, or the insecticide, and the eyelid involvement due to the same contactant transferred to the eyelids by the fingers. Patch tests proved that the contactant responsible for all the trouble was mushroom itself. Three tests were applied, mushroom, mushroom dusted with the insecticide, and the insecticide alone. The latter produced no reaction on the skin, whereas both the pieces of mushroom produced equally violent positive reactions.

The patient was removed from all contact with mushrooms, boric acid solution compresses were applied, and within seven days return of the affected parts to normal was almost complete.

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ANNOUNCEMENT

DIABETES DETECTION WEEK—NOVEMBER 16-22, 1952

For the past two years the Diabetes Detection Committee of the Medical and Chirurgical Faculty has cooperated with the American Diabetes Association in sponsoring Diabetes Detection Week in Maryland. The work of the Committee has had two main parts—first, an intense educational campaign using press, radio, and television stressing the early symptoms of diabetes and urging the public to go to their doctor for a urine test during Diabetes Detection Week, and second, arranging with a group of hospitals for special diabetes detection clinics to be held during this particular week. Last year seven hospitals participated and examined a total of 1161 persons. Of these 72 or 6% were diagnosed for the first time as having diabetes. The success of the educational program urging examinations especially for persons who were overweight, or had symptoms of diabetes or a family history of diabetes, is indicated by the high percentage of those who were found to have diabetes among the groups attracted to the examining clinics.

This year there will be a change. It is our aim to make the campaign effective throughout the state with your cooperation. It is planned not to use centers in hospitals during detection week, and to place emphasis on the educational program. The symptoms of diabetes will be stressed as in previous campaigns and the advice will be: "If you have any of these symptoms *go to your doctor for a test for diabetes.*" This approach cannot work unless there is a full measure of cooperation from practicing physicians. In the publicity no reference will be made to "free" tests and the matter of charges will be left to the discretion of the individual physician. We are confident that you will want to cooperate in this effort to locate and bring diabetics under control and to demonstrate to the Maryland public that practicing physicians have a deep and sincere interest in their welfare, not only while sick, but in preventing serious illness by early diagnosis and prompt treatment.

We have a moderate supply of small posters and educational pamphlets which are available to you on request to the office of the Medical and Chirurgical Faculty.

Our objective with the public during Diabetes Detection Week is to focus attention on this controllable disease and to steer patients to the family physician if disease is suspected. Our objective with you is to urge you to be alert to the possibility of diabetes in your every day practice and to stimulate more extensive and routine use of the modern, simplified urine tests for sugar. Let each physician's office be a diabetes detection center, not only during this week but throughout the year.

THE DIABETES DETECTION COMMITTEE

ARTICLES OF INTEREST

THE ROLE OF THE PHYSICIAN AS A CITIZEN*

AMOS R. KOONTZ, M.D.

The annual meeting of this Society in 1950 was made notable by two addresses. Dr. Albert Chatard, a beloved past-president of the Faculty, gave us a fascinating and charming description of The Doctor—Past, Present, and Future. Dr. Chatard was brought up under that *ideal physician*, Dr. William Osler. He himself has all of his life been one of the leading exemplars of the ideal physician. In his address he again held up that ideal, which I hope that most of us in our professional careers have been *striving* to attain. The other notable address to which I referred was that of our present President, Dr. Austin Pearre, who in a preeminently scholarly and thoughtful address showed us some of the *accomplishments of our country and of our profession*, and also showed how those accomplishments are now being threatened by influences and trends familiar to all of us. Dr. Pearre showed us how, not only the ideals of our profession, but the sacred principles upon which this country was founded, are in danger of being overthrown by a combination of *unscrupulous political planners* and of *visionary impractical theorists*, neither of which has any place in a society characterized by the hard-headed common sense which has always been characteristic of the American people.

It is hardly necessary for me to dwell on the dangers. We are all entirely too familiar with them. The question is what to do about it. The times certainly call for action on our part. The time for talking is over. The time for action is here *now*. *War has been declared*—war against all that we have always held dear and considered worthwhile. If you do not believe it, read some of the current campaign literature, in which one of our major political parties talks about “Better medical care that you can afford.” We all

know that socialized medicine has not proven to be “better medical care” in other countries, and the cost in taxes has been many times higher than the cost of private medicine.

Most of us have been brought up to think that our ancestors, by winning the Revolutionary War, had gained for us an independence such as no other people had ever enjoyed. That was true. Most of us also were brought up to take for granted that that independence would be a *lasting matter*. We have learned by bitter experience that independence is *not* a stable thing, but something that has to be continually *fought for* if it is to be preserved. We are now engaged in our Second War of Independence, and if we do not get out and fight for it, as did the patriots of 1776, we shall certainly lose it. Our opponents are ever vigilant. They work over *week ends* and *holidays* in order to catch us napping. They are trying to destroy the principle of *local self-government*, which is the foundation stone of democracy, and to concentrate all power in Washington. Local self-government cannot be handled from Washington. One of the greatest debates in history was centered around that very question. I refer to the debate in the Virginia Convention of 1788 on ratification of the Constitution. All members of that Convention were looking for a method of forming a more perfect union. The only question was whether the Constitution, as framed by one of the Convention's own members, James Madison, *would* preserve the rights of the states and the principle of local self-government or would gradually allow all power to be concentrated in the central government. Arrayed on the side for ratification of the Constitution were such great statesmen as James Madison, John Marshall, Edmund Pendleton, Edmund Randolph, George Wythe, Lighthorse Harry Lee, and Bushrod Washington. George Washington was not a member of the Convention, but favored ratification and lent the weight of his influence for it through correspondence from Mount Vernon. (Jefferson was in the then far away Paris, as Minister to France, and was not involved in the debate at all.) Lined up on the side against ratification were equally great men, such

*Read before the Semi-annual meeting of the Medical and Chirurgical Faculty of the State of Maryland, Frederick, Maryland, September 28, 1950.

as Patrick Henry, George Mason (who wrote the Bill of Rights), Benjamin Harrison, Richard Henry Lee, John Tyler, and James Monroe. Never did any question of personal interest enter into the debate. Never was a debate conducted on a higher plane. Seldom, if ever, in all history have such great orators been arrayed against each other, and although they *were* arrayed against each other, they were motivated by one common purpose, and one purpose only, and that was what was best for the budding nation. The only difference of opinion was that those *for* ratification believed that the Constitution *would* safeguard the interests of the people and preserve the principle of local self-government. Those *against* ratification believed that the Constitution would allow the governing power gradually to become concentrated in the central government and that this *would eliminate* the principle of local self-government, making the States mere satellites of the central body. Were all those great debaters alive today, they would be on the same side, fighting against the destruction of the dignity of the individual and of the independence of the local community. They would be amazed that the Washington bureaucrats had succeeded in doing just what the Constitution meant they should not do.

The advocates of the so-called reforms, which have been going on in our government during the last decade or two, will tell you that their plans are *not* socialistic. Some of us, however, have been studying the dictionary longer than they have, and are capable of interpreting it better. I shall not bother you with quoting Webster to prove that their plans are socialistic. I know that that is unnecessary for this audience. I will concede, for instance, that Federal aid to medical schools by itself is not socialism, but Federal aid to medical schools, *plus* TVA, *plus* social security, *plus* the Brannan plan, *plus* national compulsory health insurance, *plus* the redistribution-of-the-wealth schemes, practically would make us a *purely socialistic state*. There are too many people who talk one way and act another, both in and out of Congress. There are too many people who decry socialism, but who want to get help from the Federal government *for their own particular school*, or their own particular locality, not realizing (or seeming not to realize) that if the Federal government gives

help to *enough things*, we will have no government except the Federal Government, because the Federal government will have *all the money*, and not only will our local independence be gone but the country will be bankrupt as well.

Last year Maryland paid \$754,000,000 in Federal taxes and got \$50,000,000 back. If we were allowed to keep our own money, as the Constitution meant for us to do, and run our own affairs, it is obvious that we would not have to ask anybody for money for anything.

Robert Louis Stevenson once spoke of the doctor as "the flower of our civilization," and most eloquently gave his reasons for thinking so. You and I have been brought up to think that we belong to a noble profession, and I am sure that most of us have strived, some valiantly, some feebly, to play the part. We do belong to the greatest profession in the world, but there are a lot of doctors who take advantage of that fact, and live on its prestige instead of contributing to the advancement of it. Recently, and by recently I mean within the last five years, there have been constant slurs at the doctor, in newspapers, in public meetings, and in individual conversations. Why is this? The answer is not far to seek. There has been a smear campaign, against the doctor, conducted from Washington, *at our expense*, in an effort to belittle him, to humiliate him, to browbeat him, to make him appear mercenary, and in every way to decrease the public regard for him. Again I ask what is the reason for this, and again I say that the answer is not far to seek. If the people of this country can be gotten to think that the doctor is a *bad person*, there is more chance of passing the bill for National Compulsory Health Insurance, which everyone knows, who has studied the situation and the history of such bills in other countries, would cause a marked deterioration in the quality of American medicine, which is the best medicine in the world, in spite of the fact that certain people, with insufficient information, claim that certain small countries have better medicine than we have. I could go into this in great detail but there is not time for it. I would like to ask you, however, why the Swedes live longer in Minneso'a than they do in Sweden, and why the Norwegians live longer in North Dakota than they do in Norway?

Now why are these Washington bureaucrats so

anxious to get the bill for National Compulsory Health Insurance passed? The answer is again not far to seek. It is because the bill, if enacted into law, would provide for the expenditure of additional *untold billions* of dollars from the central authority of Washington, and that would give Washington still more power to centralize *all government* in one spot, and make every village and hamlet in this great land of ours dependent upon the central government for their very existence. Such a state would be a totalitarian state and every vestige of our democracy would be gone under it.

And what concrete plan shall we adopt? What is the simple duty of each one of us? Someone has said that the doctor must get into politics. It could be more *accurately* said that the doctor has been *thrust* into politics. I therefore urge each of you to organize *political action committees* in your own localities. You cannot do this as a medical society but you can do it as individuals. Every doctor should consider himself a *citizen* first of all. Your obligation as a citizen even supersedes your obligation as a physician. It follows then that it is incumbent on all of us to form groups for political action in order to save our country from destruction. One of the prime objects of such groups should be to see that *all physicians*, and *their families*, are not only registered to vote, but that they go to the polls and *vote* on election day. I believe it is the duty of *each physician* not to make appointments on election day, but to spend all the time he can (aside from emergencies) *on the telephone* checking to see whether people have voted, calling them and asking them to vote and *taking them to the polls* if necessary. In all of this work your wives can be of great help. They not only have more time, but are more willing workers. And right here I would like to pay a tribute to the magnificent work that the Ladies' Auxiliary, so recently organized, has already done.

Some may say that the doctor is *out of his sphere* in engaging in public affairs. Maybe so, but if so, then Dr. Warren was out of his sphere when he so valiantly led the American forces at Bunker Hill, and died in so doing. By getting out of his sphere and playing a role *far from his customary one*, he showed himself to be a great patriot and his name will be immortal as long as the flame that lights the candle of American liberty still burns. It is up to us to

keep that flame burning. *Talking* will not do it. Concerted *action* on the part of all of us is mandatory.

Some people ask me why I get so excited about socialized medicine. I am not excited about socialized medicine, in spite of the fact that I do abhor *every single form* of socialism. I am, however, excited about *my country*, and I deprecate the fact that we are allowing *unscrupulous planners* and *hopeless visionaries* to drag us down the primrose path of dalliance, when we should be *springing to arms* to fight the evil forces which are trying to destroy us. In this Second War of Independence in which we are now engaged, we need the fighting spirit of 1776. We need to be excited to the point that our *determination is so stiffened* as to give us *the will and the character* to preserve an independent and free America for our children, and our children's children, instead of allowing them to become *vassals* of a socialistic or communistic state. This will require *fighting continuously* and in the most unexpected places for some years to come. Let us take a leaf from the book of that first citizen of the world, Winston Churchill, who said "We shall fight on the beaches, we shall fight on the landing grounds, we shall fight in the fields and in the streets, we shall fight in the hills; we shall never surrender."

On a subsequent momentous occasion Churchill attended a moving church service on board the British battleship "Prince of Wales." Not many months afterwards that great ship was sunk by the Japanese. In writing of the occasion after the war, Winston said "It was a great hour to live. Nearly half of those who sang were soon to die." If we do not fight to preserve our liberties and to insure ourselves better government, we *deserve* to be vanquished. *Sitting idly by and talking about it will not help*. Only unselfish work on the part of *all of us* will insure us the preservation of our liberties.

Some of the most distinguished members of our Medical Society have criticized the methods of some of us as being undignified. This criticism has been especially directed at the production of the comic booklet satirizing socialized medicine. I shall not contest the point. If we were completely dignified, we would entirely ignore the base and unjust attacks being made on our profession by certain agencies in Washington. We would sit by in stony silence and

some day wake up to find that we were all faced with the choice of becoming government employees or giving up our profession. We have got to fight the devil with fire. The devil I refer to is not the traditional specter with horns and a forked tail, but is personified by certain malign influences, from which emanate the most noxious and nauseous vapors that ever offended the nostrils of a free and independent people. If we want to remain free and independent, we will have to use every means at our disposal. Remember that the voter who does not understand the customary dignity and aloofness of our profession is more easily swayed by comic strips than he is by logic. His cross on the ballot is just as effective as that of the most learned professor and profound scientist in the country, and he is more numerous. The people who will listen to logic and serious talks are already on our side. We want to get the people who have only mentality enough to read a comic strip. Their votes count just as much as ours.

To wage the fight successfully requires *character* of the type that Churchill exemplified all the time he was Britain's war-time Prime Minister. Horace Greeley once said: "Fame is a vapor, popularity an accident, riches take wings, those who cheer today will curse tomorrow, only one thing endures—Character." If we haven't already got it, we must develop the *character* to stand for great principles, and exhibit the *stamina* necessary to fight for the right implied in them, no matter how much against our own self-interest that fight might be.

In closing, let me quote the words of two great Americans. First, Woodrow Wilson: "The history of liberty is the history of limitations of government power, not the increase of it." The other is from Patrick Henry: "I have but one lamp by which my feet are guided, and that is the lamp of experience. I know of but one way of judging the future, and that is by the past." Let us follow Patrick Henry's advice, and take a look at the past. Let us look at England, to mention only one of the countries which has fallen for socialism, and then let us turn our faces *steadfastly* in the other direction.

And finally, in paraphrase of another quotation: May God give us the serenity to accept that which *cannot* be changed, the courage to change what *can* and *must* be changed, and the wisdom to know the difference between the one and the other.

NOTES ON PHYSICAL THERAPY¹

by

MARYLAND STATE BOARD OF PHYSICAL THERAPY EXAMINERS

The wise use of Physical Therapy will be a most valuable aid to the physicians of Maryland.

This is a brief review of Physical Therapy and a short bibliography.² The reference material will be available at the Library of the Medical and Chirurgical Faculty of Maryland, 1211 Cathedral Street, Baltimore, Maryland. A list of Physical Therapists licensed to practice in the State of Maryland may be obtained without charge from Mr. C. W. Gaines, 2411 North Charles Street, Baltimore 18, Maryland.

It is hoped that this article will be a step toward the development of intelligent teamwork between the Physical Therapist and the Physician.

Definition

Physical Therapy is defined in the Law of Maryland as the treatment of human injuries, diseases or disabilities by means of the healing properties of exercise, massage, ultraviolet rays, mechanical devices, heat, cold, air, light, water, and electricity; but not by means of Roentgen rays, radium, surgery or drugs; and a *Physical Therapist is defined as one who treats only patients diagnosed and referred by licensed medical doctors*. In a broader sense, physical therapy includes "therapeutic teaching" as well as the administration of physical treatment procedures, since patients and relatives may need to be instructed in muscle re-education technics, the use of prosthetic devices and other treatment procedures.

Practical Use of Physical Therapy

Ideally the doctor and physical therapist function as a team. If the doctor feels that physical therapy is indicated, he may send the patient to the physical

¹ Editor's Note: The State Board of Physical Therapy Examiners wishes to acquaint doctors with some of the basic features of Physical Therapy. It is hoped to stimulate interest toward a better understanding and use of Physical Therapy.

² Excerpts from "The Job of the Physical Therapist," published by the American Physical Therapy Association, are included in this material.

therapist with the diagnosis, including any additional information needed to understand the patient's condition, and a statement of the results he wishes to obtain. The doctor may specify what treatment is to be given or he may discuss the treatment plan with the physical therapist. *The Physician and the Physical Therapist should be free to discuss their patient problems with each other.* The physical therapist should report the patient's progress; and this progress report should include any unusual symptoms or adverse reaction or the failure of a patient to respond properly within a reasonable time.

Physical Therapy Records

A well qualified physical therapist will keep the following types of records:

- Medical diagnosis and prescription (by physician)
- Daily record of treatment given
- Progress report
- Postural examination chart (as indicated)
- Muscle test chart (as indicated)
- Joint range chart (as indicated)
- Electrical examination and diagnosis chart (as indicated)
- Resistance exercise record chart (as indicated)
- Therapeutic exercise chart (as indicated)
- Activities of daily living chart (eating, dressing, resting, etc.) as indicated

Some Indications for Physical Therapy

Although the majority of patients treated come from the orthopedic and neurological categories, patients from a wide variety of diagnostic groups may benefit from physical therapy. In a general hospital, for example, virtually every service may recommend physical therapy for some of its patients. A list of types of cases treated by a representative number of physical therapy departments follows. This list is to be regarded as typical rather than exhaustive.

- Amputations
- Arthritis
- Burns
- Cerebral disease and injury, such as cerebral palsy, cerebral vascular lesions
- Congenital deformities, such as club feet and torticollis
- Dislocations
- Fractures

- Joint and muscle disease and injury
- Obstetrical and gynecological conditions
- Peripheral nerve disease and injury
- Peripheral vascular conditions
- Postoperative surgical conditions
- Posture
- Psychiatric conditions, such as conversion hysteria
- Skin disease and injury
- Spinal cord disease and injury, such as poliomyelitis, multiple sclerosis, traumatic lesions

Treatment Modalities

- Thermotherapy or heat (diathermy, infra-red, hot packs, paraffin bath)
- Radiation or light (infra-red, ultraviolet)
- Hydrotherapy or water (whirlpool bath, contrast bath, Hubbard tub, needle spray, cold and hot packs)
- Electrotherapy (electrical stimulation, ion transfer, short and long wave diathermy)
- Massage (general, local, relaxing, stimulating)
- Therapeutic exercise (passive motion, active assistive motion, active motion, resisted motion; breathing, posture and gait training; muscle re-education; coordination and rhythm exercise; stretching; underwater exercise)
- Miscellaneous (bandaging, strapping, removal and reapplication of splints and casts as prescribed)

Diagnostic Testing

The kinds of diagnostic testing for which the physical therapist may be responsible include (1) voluntary muscle testing (muscle power), (2) electrical muscle testing, (3) joint measurements and (4) functional activity testing (such activities of daily living as eating and drinking, dressing and undressing).

The amount of diagnostic testing which the therapist is expected to do varies from center to center. In all instances where it is performed, it is carried out under the prescription and general supervision of the physician.

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5. National Multiple Sclerosis Society
 270 Park Avenue, New York 17, N. Y.

“De-VOTE A Day to Democracy. VOTE November 4th!”

Reports

THE AMERICAN MEDICAL EDUCATION FOUNDATION

NEWLAND E. DAY, M.D.*

WHY YOUR NAME SHOULD BE HERE

In the fall of 1948, a group of University presidents under the leadership of General Eisenhower of Columbia, and President Conant of Harvard, began independently to explore the possibility of developing a campaign on a national scale to meet the degree of financial crisis that has been facing the medical schools since the end of World War II, and to advance some suggestions for its cure. At the same time, a committee under the chairmanship of Mr. Earl Bunting, Managing Director of the National Association of Manufacturers started exploring the practicality of a campaign to be developed through the cooperative efforts of the medical profession, medical schools, business and industry. When the two groups learned of each other's activities, a conference was held and an agreement was reached quickly on combined efforts. At this meeting was born a National Fund for Medical Education.

From the beginning, the national fund considered itself a wholesale organization to raise funds for corporations and other large organized groups. It was understood that the American Medical Association would have to assume the responsibility for raising funds for the Medical profession. *By late 1950, it appeared likely that the national fund would be in a position to make a public announcement in the spring of 1951 if a substantial sum could be provided by the medical profession by that time.*

In December, 1950, the Board of Trustees of the A. M. A. generously appropriated \$500,000 to start the ball rolling, and this was followed quickly by the organization of the American Medical Education Foundation, the initiation of a fund raising campaign among the members of the medical profession.

In July, 1951, the Foundation and the Fund com-

bined, were in a position to make the first stab at the medical schools. During the first year, only sufficient funds were raised for Class A and Class B grants (see previous article), totaling just over one-half million dollars, and were only less than half the size than hoped for. This year the Fund hopes to contribute at least \$4,000,000 annually in "A" and "B" grants and to have further sums available for Class "C" grants. Voluntary enterprise should be one of the originators of this splendid arrangement. It is of interest to note that one of the presidential candidates, Mr. Eisenhower, was one of the founders of this move to encourage voluntary enterprise in the project to keep medical schools free and independent.

Maryland contributors to the American Medical Education Foundation, January 1, 1952, to July 31, 1952, are as follows: February Contributors—Thurston R. Adams, Baltimore; Walter A. Baetjer, Baltimore; George E. Bennett, Baltimore; Stuart M. Christhilf, Jr., Annapolis; Jesse C. Coggins, Laurel; Archibald R. Cohen, Clear Springs; Mary R. S. Farber, Sparrows Point; Paul N. Friedman, Baltimore; Palmer H. Fletcher, Baltimore; David J. Gilmore, Salisbury; Albert E. Goldstein, Baltimore; Francis F. Greenwell, Leonardtown; Donald B. Grove, Cumberland; Rachel K. Gundry, Baltimore; Frank Y. Jaggars, Jr., Chevy Chase; Nathan Janney, Baltimore; Bernard S. Kleiman, Baltimore; Erasmus H. Kloman, Baltimore; Charles B. Marek, Baltimore; Charles W. Maxson, Baltimore; Robert S. McCeney, Laurel; Randall M. McLaughlin, Pasadena; Henry C. A. Mead, Sykesville; Elmer P. Sauer, Mt. Wilson; Douglas H. Stone, Baltimore; Merrell L. Stout, Baltimore; Edward L. S. Vendel, Baltimore; Sullins G. Sullivan, Baltimore; Richard W. TeLinde, Baltimore; Walter D. Wise, Baltimore; Arthur O. Wooddy, La Plata; Israel S. Zinberg, Baltimore; Edwin D. Weinberg, Baltimore; March

* Chairman of the Committee to Cooperate with the American Medical Education Foundation. Medical and Chirurgical Faculty.

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Baltimore; May Contributors—Francis A. Ellis, Baltimore; Charles R. Foutz, Westminster; John E. Savage, Baltimore; Harvey B. Stone, Baltimore; June Contributor—Whitmer B. Firor, Baltimore; July Contributor—Robert B. Brown, Capt. MC, U. S. N., Bethesda.

EMERGENCY MEDICAL CALL SYSTEM FOR BALTIMORE CITY AND BALTIMORE COUNTY

PAUL E. CARLINER, M.D.*

In this era of uncertain economics and, at times, troubled public relations between physician and the public, it is imperative that organized medicine take steps to insure that proper medical care be provided at all times.

While the providing of medical care to private patients is primarily the responsibility of the physician in private practice, it is well within the province of organized medicine to see that machinery be set up to bring together in a private physician-patient relationship those persons who require emergency medical care and who either have not established a relationship with a physician or who for some reason cannot reach their physician in time of emergency.

Several years ago the State Medical Society and several of its component societies decided to set up committees on emergency medical care to prevent the recurrence of the tragic happenings reported in the press, of people dying without having been able to get a doctor to answer a call for emergency help.

The Baltimore City Medical Society in conjunction with the Baltimore County Medical Society set up a committee headed by Dr. Douglas Stone to explore the ways and means of establishing a roster of physicians willing to take emergency calls on a private physician-patient relationship.

Dr. Stone's committee set up a roster of physicians in Baltimore City and Baltimore County on a postal zone basis to handle such calls. These calls are handled through an emergency number, PL 1400,

by operators of the Physicians' Exchange which has cooperated fully in handling these calls without any charge to the Medical Society. This system is now in its fourth year of operation, and in the first four months of 1952 it dispatched physicians on 1440 emergency calls.

There is still a need for more physicians to be listed on the panel. By keeping a full roster the number of calls handled by any one physician is small.

It is proper to point out at this time that the need for an emergency call system would be slight if all physicians would assume their proper responsibility in keeping their phones covered on a 24 hour basis, so that even if the physicians were unable at any time to answer a call, a substitute would have been provided. This would prevent the picture of distraught families picking up the phone to call their family physician in an emergency and finding an unanswered phone. What follows then is a desperate period in which a family is suddenly faced with the realization that the physician upon whom they have depended for medical care is not available when needed. At times this means that several other physicians are routed out of bed by hysterical families searching wildly for medical care wherever they can get it.

While the Committee on Emergency Calls is attempting to handle emergencies when physicians are not immediately available, it can in no way take over the responsibility of physicians to their own patients.

* Chairman, Committee on Emergency Medical Call System of the Baltimore City Medical Society.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

Dr. Ralph A. Reiter opened an office for the practice of pediatrics in Cumberland, August 11, 1952. Dr. Reiter completed his studies at the University of Maryland Medical School in 1946 and then entered the Navy. While in the Navy he interned for a year at the Long Beach, California, Naval Hospital and then was transferred overseas. He was stationed in the Palau islands for a year and then was sent to duty on Guam in the Marianas. While serving on Guam, he was awarded a letter of commendation from Admiral C. A. Pownall for his work during a measles epidemic. Following his discharge from the Navy, Dr. Reiter served as resident physician at Memorial Hospital here from April, 1949, to June, 1949. He then went to the Mayo Clinic, Rochester, Minnesota, on a three-year fellowship in pediatrics, completing his work there last month. Dr. Reiter is a member of the Olmstead, Fillmore and Dodge County (Minnesota) Medical Society, The Minnesota State Medical Society and the American Medical Association.

Dr. Harry M. Robinson, Professor of Dermatology at the University of Maryland, spoke before the Allegany-Garrett County Medical Society, on the evening of Friday, September 18th, in the Nurses' Auditorium, Memorial Hospital. Dr. Robinson's subject was "Allergy Contact Dermatitis," and was illustrated with lantern slides.

Dr. Samuel M. Jacobson, 50 Pershing Street, Cumberland, Maryland, has had a paper titled

"Jaundice" published in the July, 1952, West Virginia State Medical Journal.

Dr. C. C. Zimmermann, Cumberland, is in Europe and expects to have an audience with the Pope and while in Rome will visit Dr. John Idoni, non-practitioner in Rome, specializing in surgery. Dr. Idoni is a native of Cumberland.

Dr. F. A. G. Murray, Cumberland, is said to be the oldest living active practitioner in point of years in the state of Maryland. Dr. Murray graduated from the University of Maryland in 1897. (If this is not the case, let us hear from others.)

The Medical and Surgical Staff of Memorial Hospital was entertained by the Board of Governors at the cottage of Hon. William A. Gunter, former Senator and now President of the Board, on August 20, 1952. Food for this occasion was brought from the Eastern Shore.

ANNE ARUNDEL COUNTY MEDICAL SOCIETY

GEORGE C. BASIL, M.D.

Journal Representative

Progress is being made on the plans to start the new wing and ground is expected to be broken early this Fall, for the Anne Arundel General Hospital.

Mrs. Charlotte Rawlings, Mrs. Imelda Russell, and Mrs. Mary Crandall attended the annual Nurses Convention in Atlantic City in June.

Dr. John McMann Claffy expired suddenly at his home, July 26th, 1952. He had practiced for many years in Anne Arundel County, was a member of the staff of the Hospital, and coroner for Anne Arundel County for several years.

"Get-Out-The-Vote"

Meetings of the Baltimore City Medical Society and its Sections
All these meetings will be held at 1211 Cathedral Street unless otherwise stated

BALTIMORE CITY MEDICAL SOCIETY

SAMUEL McLANAHAN, M.D., *President* EDWARD F. COTTER, M.D., *Secretary*
 J. ALBERT CHATARD, M.D., *Treasurer*

Friday, November 21, 1952, 8:30 p.m.

PANEL DISCUSSION: DIETS

George V. Mann, M.D., *Moderator*, Assistant Professor of Nutrition, Harvard University School of Public Health, Boston, Massachusetts

Cardiac Diets. E. Cowles Andrus, M.D.

Obesity. John Eager Howard, M.D.

Dermatology. R. C. V. Robinson, M.D.

Obstetrics. Nicholson J. Eastman, M.D.

Hypertension. George V. Mann, M.D.

Dietetics. Mrs. John H. Trescher

This is an unusual opportunity for all those who are interested in the various branches of diets to participate and ask questions in the discussion period which will follow the panel discussion.

SECTION ON DISEASES OF THE CHEST

MOSES S. SHILING, M.D., *Chairman* EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, November 5, 1952, 8:00 p.m.

Fungus Diseases. (Illustrated.) Chester W. Emmons, Ph.D., Principal Mycologist, U. S. Public Health Service, National Institute of Health, Bethesda, Maryland. (By invitation.)

SURGICAL SECTION

E. RODERICK SHIPLEY, M.D., *Secretary*

The following officers were elected by the Surgical Section of the Baltimore City Medical Society at their meeting on May 23, 1952:

Daniel J. Pessagno, M.D., *Chairman*

Edgar F. Berman, M.D., *Vice Chairman*

E. Roderick Shipley, M.D., *Secretary-Treasurer*

The new chairman, Dr. Pessagno, has appointed a committee which will act as a grievance committee to whom members of the Surgical Section can take their problems and complaints that deal with the Blue Shield. It is hoped that any misunderstandings may be avoided in this manner. The committee is composed of:

Karl F. Mech, M.D., *Chairman*

Otto C. Brantigan, M.D.

William E. Gilmore, M.D.

The Surgical Section did not meet in October.

BALTIMORE COUNTY MEDICAL ASSOCIATION

DONALD L. SOMERVILLE, M.D.

Journal Representative

A recent meeting of the Baltimore County Medical Association was held at Ames Friendship Hall in Pikesville, where the members were guests of the Minister and the gracious ladies of the church, who prepared a delicious luncheon as always. General James P. S. Devereux, Congressman from the 2nd district, was the distinguished speaker of the afternoon, and his topic was one of intense interest; General Devereux is one of the medical profession's truest champions in its fight against the insinuation of socialism into our profession and into society in general. He gave a concise resume of H.R. 7800, a bill designed to change the Social Security laws, and which in part consists of what has been called "the opening wedge to socialized medicine." This seems an apt term, for, as General Devereux explained, the portion of the bill applicable to the medical profession directly would authorize the Social Security Administrator to decide who should examine disabled persons (as well as where and when they should be examined) to determine the extent of their disability, and thus to determine their eligibility for a waiver of premium toward eventual Social Security benefits. He explained that the bill was literally forced through the House of Representatives, but was slowed down in the Senate for further consideration and possible future changes, especially with regard to the aforementioned provision. The General enlightened the members further with an explanation of just what Socialism really is and what it can do: Socialism and Communism have the same goal, achieved through different means. That goal is to produce a nationwide complete dependence on the government, through power achieved by utilizing the existing type of government by infiltration of one type or another. The magic keyword of this achievement of power is "Reform." The assembled physicians certainly took away with them a clearer picture of this menace from one who has had an opportunity to observe it at work, all of which should aid them in communications which are to the point to their senators and congressmen.

Following General Devereux's presentation, sev-

eral pieces of business came before the group. First of these was a motion that the Association's delegates to the Medical and Chirurgical Faculty be instructed that it is the Association's desire to continue the Medical Care Program (seriously handicapped now by a cutback in funds of \$100,000) as it has been in the past, with prorating when funds are low. This decision was arrived at by a vote of the majority of members of the Association, all of whom were sent letters that were actually ballots on which they voted for the solution to the problem which they favored. The majority who replied favored the prorating idea. Many of the replies to this voting contained comments, and it was obvious from these that many physicians have been doing medical care work for years without billing the state at all. The motion was passed unanimously.

The final item of business was an address by Mr. William Wells, legal advisor to the Association. Mr. Wells discussed the pros and the few cons involved in incorporation of the Baltimore County Medical Association, and convinced everyone present that the group would profit legally and practically by becoming a Corporation. It was so moved and passed.

Dr. Samuel Scalia, Chairman of the Public Relations Committee, will be sent by the Association to Chicago in September to attend the A. M. A.'s first Institute of Public Relations. Dr. Scalia will undoubtedly return to us well-armed with suggestions from the national organization. We look forward to his report.

DORCHESTER COUNTY MEDICAL SOCIETY

WALTER B. JOHNSON, M.D.

Journal Representative

Dorchester County is the largest (in area) of the nine counties which make up the Eastern Shore. It is separated on the north from Talbot and Caroline Counties by the Choptank River, and on the south from Wicomico and Somerset Counties by the Nanticoke River. It is bounded by the Chesapeake Bay on the west and southwest. The eastern boundary is common with the State of Delaware. The 580 square miles of surface are generally flat and are cut by many rivers which empty into the Chesapeake Bay.

The population was just under 28,000 at the latest census, with 10,500 of this number in the City of Cambridge. The other almost two thirds of the county population is rural, with agriculture, oysters, crabs and fishing being the main occupations. About 25 per cent of the population is colored.

The doctors practicing in Dorchester County are distributed as follows:

administrative offices, record room, dining room, laboratory and x-ray rooms. One operating room is added and the operating room suite is improved and modernized. A cystoscopic room is added in conjunction with x-ray.

The old building has been rewired and a sprinkler system installed, large storage and drug rooms are provided.

DOCTOR	TOWN	POPULATION	SPECIALTY
Brown, Hugh	Cambridge	12,000	General Practice
Brown, Robert	East New Mkt.	800	General Practice
Bunker, A. E.	Cambridge	12,000	General Practice
Gunby, Walter E.	Cambridge	12,000	General Practice
Hanks, Wm. H.	Cambridge	12,000	Surgery-General
Harrison, Wm. C.	Hurlock	1,000	General Practice
Mace, John	Cambridge	12,000	Surgery-General
Maryanov, Lawrence	Cambridge	12,000	General Practice
Maryanov, Alfred R.	Cambridge	12,000	Radiology-General Practice
Meade, James	Cambridge	500	General Practice
Meekins, Gilbert	Cambridge	12,000	General Practice
Miller, Frederick	Cambridge	12,000	Eye, Ear, Nose & Throat
Steele, Guy	Cambridge	12,000	General Practice (Semi-Retired)
Thompson, James U.	Cambridge	12,000	General Practice
Wolff, E. H.	Cambridge	12,000	General Practice
West, G. Brooks	Cambridge	12,000	Ear, Nose & Throat
(Col.) Wilson, H.	Cambridge	12,000	General Practice
(Col.) Brady, S. E.	Cambridge	12,000	General Practice

FREDERICK COUNTY MEDICAL SOCIETY

JESSE S. FIFER, M.D.

Journal Representative

Frederick Memorial Hospital is now putting the finishing touches on its million dollar improvement program.

The former 125 bed, 24 bassinet capacity, is now 160 beds and 37 bassinets.

A new Gambrill wing to the south has been added, costing one hundred thousand dollars, containing the emergency rooms, central supply and autopsy room.

A new North wing has been added, the first floor, private rooms, the second floor, semi-private and ward accommodations, and the third floor, a new obstetrical sweep, with modern nursery, formula, labor and delivery rooms.

Remodeling of the old part of the hospital alters most every department, giving enlarged, modern,

A wing has been added to the nurses home, providing for 28 additional persons, modern well equipped laboratories and class rooms for the school of nursing.

Two new general practitioners have started their practice in Frederick recently. Dr. Rex R. Martin, single, whose home state is West Virginia, and received his degree in medicine from Johns Hopkins Medical School, June 1950, started practice July 1, 1952.

Dr. Ernest J. Dettborn, a native of Baltimore, received his degree in medicine June 1951 from the University of Maryland, School of Medicine. He has a wife, formerly Miss Helen Stoner, from this county, and 2 children. He started practice August 1, 1952.

The Frederick Memorial Hospital building program is completed. Our staff has been recently organized into departments, which includes: Medicine, Pediatrics, General Surgery, Urology, Otolaryngology, Ophthalmology, Obstetrics, Pathology, Roent-

genology. All these departments are headed by well trained men in their respective specialties.

Dr. Robert J. Furie started at The Frederick Memorial Hospital on August 1st, as full time pathologist. He is a native of Massachusetts and a graduate of Boston University Medical School and comes from Georgetown University Medical Center.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

SAMUEL J. N. SUGAR, M.D.

Journal Representative

The Prince George's County Medical Society held its first Golf Tournament June 5, 1952. Trophies were awarded to Lloyd Hughes, low net; Fred Musser, low gross; and Al Roth, high gross. An excellent dinner and refreshments followed the afternoon's play.

A speakers' list is being drawn up to address various PTA groups when school reopens.

Dr. Ronald Fleischer has been appointed Chairman of the County Diabetes Detection Drive to be held in November.

Dr. Proctor Harvey of Georgetown University Medical School presented an interesting paper on "Cardiac Auscultation" at the June meeting.

At the October meeting Mr. Theodore Wiprud will give a very interesting talk on Medical Economics.

A speakers' bureau has been set up to address Parent-Teachers Associations who desire medical talks on various subjects.

The annual Diabetes Detection Drive will be under the supervision of Dr. Ronald Fleischer.

Arrangements for the annual Medical Society Dinner and Dance are being completed and this event will be held in early November.

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AMERICAN MEDICAL ASSOCIATION OFFERS AID TO DOCTORS DISCHARGED FROM MILITARY SERVICE

American Medical Association News Notes, Vol. 1, No. 5, August, 1952

A new program has been set up by the American Medical Association to acquaint physicians newly-discharged from the armed forces with existing opportunities in private practice, industry, hospitals and medical schools throughout the country. Inaugurated by the Council on National Emergency Medical Service, the plan incidentally will also provide replacements for physicians classified priority I under the "Doctor Draft Law" who are now deferred from active military service because of essentiality.

The Council will contact army, navy and air force physicians before they are discharged to find out if they have any post-service plans. If the doctor hasn't made any plans, he may indicate to the Council where he wants to locate and in what field of medicine he is interested. This information will be sent to state medical societies and to state medical advisory committees to the Selective Service System. Correspondence with individual physicians on these lists will be handled by either the state advisory committees or the medical societies.

* * * * *

ARMY ANNOUNCES PROGRAMS TO EASE SHORTAGE OF NURSES

A. M. A. Capitol Clinic, Vol. 3, No. 32

Army Medical Service is planning two steps in an attempt to ease the shortage of nurses. It will broaden its practical nurse training program this fall with two new 48-week courses in advanced medical-technical procedure, opening October 27th in Dallas and San Francisco. Army also plans a 3-month intensified campaign starting next February for recruitment in the Army Nurse Corps and Women's Specialist Corps. If the call for 500 nurses and 125 medical specialists can't be met by volunteers, Army will begin calling women from its organized and voluntary reserves. Meanwhile, Air Corps says it is getting enough nurses through volunteers and Navy reports an adequate supply of nurses through voluntary recruitment of reserves.

Library

JOHN FONERDEN, THE FIRST LIBRARIAN

Although little has been recorded about Dr. Fonerden in the brief biographical sketches, it is evident that he took an active interest in the affairs of the Faculty and contributed to a new way of thinking in his service of caring for the insane.

John Fonerden was born in Baltimore on January 22, 1804. He received his degree, Doctor of Medicine, from the University of Maryland in 1823, when he was only nineteen years old. He was the Attending Physician, Baltimore General Dispensary, 1826-28; President, Medico-Chirurgical Society, 1831; Orator, Medical and Chirurgical Faculty, 1833; Secretary, Medical and Chirurgical Faculty, 1828-34; Librarian of the Medical and Chirurgical Faculty, 1830-34; City Physician, 1832; Professor of Obstetrics and Diseases of Women and Children, Washington University, Baltimore, 1845-46; Medical Superintendent, Maryland Hospital for the Insane, 1846-69; Vice-President, Medical and Chirurgical Faculty, 1854-55.

In response to the resolution, made at the annual meeting of 1830 by Dr. Samuel Baker to appoint a Library Committee to purchase periodicals and other standard works in medicine for the use of the members of the Faculty, large donations of books were made by Faculty members. Among the first contributors was Dr. Fonerden, who had been appointed Librarian of the Medical and Chirurgical Faculty in 1830. It is interesting to note that the salary at this time was \$100 per annum.

"The existence of such a collection," said Dr. Fonerden, Chairman of the Library Committee, "as the catalogue of this library announces to be at the command of the members of the corporation throughout the State, is one of the results of the care with which the Faculty has endeavored to use its funds wisely for a permanent diffusion of medical and surgical knowledge."

In 1833 a small catalogue was printed, listing the holdings of the library. In 1834 the librarian was directed to have printed a supplement to this cata-

logue. It is probable that the famous 1835 catalogue was the result of this direction. This catalogue contains a list of 569 entries of books purchased and gifts received during the first five years. By 1840 additional entries made in writing increased the number of holdings to 979. This small catalogue of 1835 with the interleaved additions was the property of the Armed Forces Medical Library from the latter part of the nineteenth century until 1948, when it was graciously returned to our library.

Another phase of Dr. Fonerden's career was in his appointment as Superintendent to the Maryland Hospital for the Insane, now called the Spring Grove State Hospital, in 1849. He held this office for twenty-three years, or until his death.

Dr. Richard Sprigg Steuart, the President of the Board of Managers of the Maryland Hospital, wrote that Dr. Fonerden "had a calm, benevolent, yet determined expression of countenance that gave command to all around him and seldom had he to resort to other means than personal manner to control his subjects. Though his position was subordinate, the perfect harmony between his chief and himself, made but one mind in operation, and for twenty-two years he had the unlimited control of the Maryland Hospital, and the highest confidence of its Board of Visitors."

During Dr. Fonerden's service, the hospital passed through a trying period. The financial situation, resulting from the Civil War, made it almost impossible to collect payments from the counties for their patients. The existence of the hospital during the sixties was a precarious one.

From his reports, it is apparent that Dr. Fonerden had a keen appreciation of the needs of the insane and a clear understanding of the causes of mental disease and the measures necessary to prevent mental illness.

Dr. Fonerden was one of the Charter Trustees of the Johns Hopkins University and Hospital. Unfortunately, he did not live to see the realization of the plans that had been made for this institution, since Dr. Fonerden died in Boston at the Massachusetts General Hospital on May 6, 1869.

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- Herring, A. P., John Fonerden, *Bull. M. Chir. Fac. Maryland* 6, 53-61, October 1913
- Catalogue of books belonging to the Library of the Medical and Chirurgical Faculty of Maryland, Baltimore, John D. Toy, Printer, 1835

THE DR. SAMUEL BAKER FUND

One hundred and twenty-two years ago, at the annual convention of the Medical and Chirurgical Faculty, the following resolution was offered by Dr. Samuel Baker of Baltimore: "Resolved, That a committee of five, to be called a Library Committee, be appointed to purchase such periodical and other standard works in medicine as they may deem proper, to be placed in some suitable situation for the use of the members of the Medical and Chirurgical Faculty of the State; and that this committee be authorized to draw on the Treasurer for an amount not exceeding \$500 for the purpose above-mentioned, and that this committee report at the next meeting of the convention. It is also made the duty of this committee to draw up such rules and regulations as may be necessary for the safe keeping and management of the library so procured. Committee: Samuel Baker, Peregrine Wroth, Wm. W. Handy, John Fonerden and H. W. Baxley." Dr. Baker continued to act as the chairman of this committee until his death.

Samuel Baker was born in Baltimore on October 31, 1785. His early education was received at the James Prestley's Academy in Baltimore. At the age of fifteen he was sent to Chestertown, Maryland, to complete his classical studies under Dr. Ferguson. He returned to Baltimore and entered the apothecary of Dr. Henry Wilkins to gain a practical knowledge of pharmacy. Later, he became a pupil of Dr. Miles Littlejohn and Dr. William Donaldson. In 1806 he entered the University of Pennsylvania. At this time Benjamin Rush, the father of American Medicine, was at the height of his medical career. His other teachers were Barton, Shiley, Wistar,

Woodhouse, Physick and Dorsey. After attending two courses of lectures, he received the degree of Doctor of Medicine and returned to his native city to practice.

He took an active part in the professional life of the city. Six months after he began his practice, he was elected Professor of Materia Medica in the College of Medicine of Maryland, which later became a part of the University of Maryland. From the moment of his entrance into the University, its history became identified with his labors, his talents and his zeal. He was a pioneer in the upbuilding of Baltimore as a medical center.

His career as a public professor terminated in 1833. It has been said that the successive unpleasant difficulties, which harassed the University at this time, made a disagreeable situation and the demands upon his time from his practice were such that it became necessary to retire from this position.

The records state that "the disease which proved fatal was so illusory that but little apprehension was felt for him until a day or two prior to his dissolution. He died at the ripe age of 50" on October 16, 1835.

He has left behind him a monument of his interest in and a devotion to science, which can never be forgotten. It was through his instrumentality and at his suggestion that the Library of the Medical and Chirurgical Faculty of Maryland was instituted.

In 1901, Dr. S. T. Earle, President of the Faculty, announced that by the will of the late Mrs. Ellen Baker, \$1,000 was bequeathed to the Faculty in memory of her father, Dr. Samuel Baker, to be used as a special fund, the interest of which is to be applied to the purchase of books relating to materia medica and therapeutics.

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The Faculty Bookplate is used and the Baker Fund is so designated.

Health Departments

MATERNITY CARE IN MARYLAND'S COUNTIES— THE ROLE OF THE STATE DEPARTMENT OF HEALTH

JOHN WHITRIDGE, JR., M.D.

BACKGROUND AND DEVELOPMENT

During the past two decades truly amazing progress has been made in safeguarding the lives of mothers and their newborn infants. For example, in 1951 the maternal mortality rate for the state of Maryland reached a record low of 0.5 per thousand live births, a notable achievement for which the medical and nursing professions of the state are to be heartily congratulated. It was, however, not always so. In a survey of maternal deaths for the three year period 1927-29 Dr. J. H. Mason Knox, Jr.¹ in his annual report to the Director of Health pointed out that the maternal mortality rate for the counties of Maryland for those years was 5.6 per thousand live births. In an analysis of 176 maternal deaths in women beyond the seventh month of pregnancy he found that only 8% had received adequate prenatal care, 56% *had received no prenatal care whatever*, and the remainder had received inadequate care. Dr. Knox concluded, "There is urgent need on the part of physicians and each community to provide at little or no expense, satisfactory prenatal and obstetrical care for women who are unable to provide this care for themselves."

As this picture of lack of adequate prenatal care came into focus Dr. Knox turned his efforts and the resources of the State Department of Health toward the organization of health department sponsored prenatal conferences. Under his guidance and with the philosophy expressed above the first such clinic was held in May of 1928 in Havre de Grace. The project was undertaken with the full cooperation of the local county health officer and with the approval of the local practicing physicians. In the subsequent twenty-four years the program has expanded slowly throughout the state, so that at present there are

62 clinic centers providing antepartum care to those in need of it in 22 of the 23 counties.

SERVICES RENDERED

In recent years approximately 2500 women annually have received their prenatal care in health department clinics. In the remainder of this brief description these patients will be referred to as clinic patients. They represent somewhat less than nine per cent of all pregnant women in the counties of the state, and eighty per cent of them are Negroes. As a group they are almost without exception indigent or medically indigent. All applying for clinic care receive a complete physical examination, urinalysis, x-ray of chest, and blood studies including serologic test for syphilis, Rh factor determination, and hemoglobin determination. When indicated, special diagnostic studies such as x-ray pelvimetry are carried out. The ultimate goal is to make available to clinic patients as modern and adequate antepartum care as possible. In addition patients receive advice concerning hygiene during pregnancy, dietary instruction, and assistance wherever possible with social and economic problems.

Except in a few areas where the State Department of Health has employed certified nurse-midwives, the Health Department does not itself undertake to furnish delivery care. Accordingly, helping the patient to make suitable plans for delivery is an extremely important function of clinic services. Since the vast majority of fatalities to mother or child will inevitably occur in those women with abnormalities, the meticulous search for all deviations from the normal becomes the very purpose and keystone of the entire project. Over the years the importance of this screening process has led to the

establishment of close relationships between the Health Department and hospitals throughout the counties and in Baltimore City. This has been done in order to make available adequate delivery or other obstetrical care to those mothers with toxemia of pregnancy, contracted pelvis, hemorrhagic complications of pregnancy, and the like. The ability to make suitable plans for patients with abnormalities is thus the very cornerstone of the program.

MIDWIFE CONTROL

When examination reveals no abnormality and when the course of pregnancy has been uneventful no urgent need for hospital delivery exists. In such circumstances clinic patients are assisted in making plans for home delivery, rarely these days by a physician, usually by a licensed midwife. The State Department of Health is charged by law with the responsibility for licensing, inspecting, and supervising the activities of all midwives in the state. The law further states that a midwife may accept for delivery only those patients who have been examined by a physician and certified by him to be normal and thereby suitable for midwife care. Normal clinic patients allowed to have midwife delivery made up slightly over 40% of all midwife deliveries in the counties. The remainder are examined and cared for prenatally by practicing physicians. Accordingly, the private physician has a definite responsibility in this aspect of maternity care. Evidence that this responsibility is sometimes taken lightly is found in the fact that the death rate in those patients delivered by midwives who have not been screened in health department clinics is nearly four times that of those attending clinics. It can be stated with sincerity that in all instances where the private physician finds his load of patients to be delivered by midwives too time-consuming, the Department of Health stands ready to assume their care. In fact, it would seem that in this very group, mostly Negroes and from the lowest economic level, lies the most logical and greatest need for health department activities in the field of maternity care in this state.

PERSONNEL

Various categories of professional personnel assist in the program being described. Local practicing

physicians, both obstetricians and general practitioners, have through the years given generously of their time in support of the prenatal clinics by acting as clinic physicians. Without this support the results achieved would have been impossible. In all but a handful of the 62 clinic centers throughout the state local physicians are serving in this manner. The county health officer cooperates by acting as clinician in the absence of another physician, and in making available clinic space and nursing and secretarial services. In six counties certified nurse-midwives are employed to supervise the county maternity program, particularly to supervise midwife activities, and to instruct general duty public health nurses. The nurse-midwives also accept a few patients each year for home delivery.

Available from the central staff of the Health Department are three types of consultant services. The first of these is a maternity nurse consultant who is responsible for the nursing and midwife aspects of the program. As such, she takes an active part in the instruction of nurse-midwives, general duty public health nurses, and especially midwives. For the latter she is responsible for arranging classes of instruction, supervision at delivery, examinations for licenses, and periodic inspection. Secondly, expert dietary advice is available from nutritionists from the central office. They furnish both direct service to patients in clinics and also instruction in nutrition to the general duty nurses. Thirdly, there is an obstetrician employed on a full-time basis by the Health Department. His activities include pre-arranged trips to most of the counties of the state to hold consultation clinics. In these clinics abnormal or suspect cases are examined and help is given in making arrangements for suitable delivery or other obstetrical care. The obstetrical consultation clinics are not limited to health department patients, in fact, physicians are welcome at any time to refer their own private patients. If more convenient to patient or physician, private patients may be seen in the physician's office, the local hospital, or the patient's home.

Last but by no means least on the list of those helping with the maternity program is the general duty public health nurse. Without her, little could be accomplished. She knows the family, is usually the first one to whom the patient turns for help,

makes home visits for a variety of purposes including preparation for home delivery, and is in general the direct source of contact with the patient.

RESULTS

In a recently completed survey² of health department clinic maternity patients over a six year period the following statistical results were ascertained: In 11,052 delivered clinic patients, 38% had been delivered in their homes by midwives. The trend toward hospital delivery for clinic patients, either electively or because of pathology, has increased steadily, reaching 60% in 1950. A comparison between clinic patients and others in the counties of the state revealed practically identical mortality rates for white patients. In Negro patients, however, neonatal, fetal, and maternal mortality rates were all approximately one third lower for those patients who had attended a clinic than for those who had not. These data were interpreted to indicate that there is a continuing need for free clinic services in Maryland for the underprivileged. A majority of present-day fatalities to either mother or child is

still occurring in women whose antepartum care has been nil or inadequate. Additional evidence that, despite the amazingly low maternal mortality rate, much still needs to be done is found in the reports of the Committee on Maternal and Child Welfare of the Medical and Chirurgical Faculty. This committee, reviewing all maternal deaths each year, still finds consistently that two of every three deaths could have been prevented by adequate care and patient-cooperation. Dr. Knox's conclusions in 1929, amended by changing one word, would read as follows: "There is *continuing* need on the part of physicians and each community to provide at little or no expense, satisfactory prenatal and obstetrical care for women who are unable to provide this care for themselves."

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2. WHITRIDGE, J. JR. AND DAVENS, E., Am. J. Public Health **42**, p. 508

* * * * *

Not the *Farm Vote* . . .
The *Big-City Vote* . . .
The *Labor Vote*
Or any *Party Vote* . . .

THE FAMILY VOTE

Will elect the Next President

Politicians talk a lot about this and that "bloc" of voters being decisive factors in this election. So do all the pollsters. You can't blame them for trying to dope it out that way in advance . . . but . . .

YOU know you're going to vote your own sweet way when you get behind that voting booth curtain—that where you live or work hasn't got a blankety-bloc thing to do with how you'll vote. You'll vote for what you believe to be in the best interests of your family—your kids—and your kid's kids.

So YOU know that this year—as always—it will be the FAMILY vote that really decides things. And families are working as never before to make sure every American votes. Right now in millions of American families, everyone from Little Sis to Grandma is pitching in to remind every eligible American to register to make sure of the opportunity to vote. And then they'll tackle the job of getting out the vote of every member of America's 44,000,000 families. They're the biggest "bloc" in America—they ARE America!

If your family is already working at the job—congratulations! If you aren't, talk it over at supper tonight, and pitch in tomorrow.

YOUR DOUBLE DUTY . . .

Vote Yourself and Help Your Neighbor Vote!

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, August 29–September 25, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARA LYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County.....	2	—	2	1	2	—	2	9	—	2	—	—	—	17	—	6	—	5
Anne Arundel.....	—	—	—	—	—	—	—	1	—	1	—	—	3	13	1	6	—	1
Howard.....	—	—	—	2	—	—	—	—	—	—	—	—	—	1	—	2	—	—
Harford.....	—	—	1	3	—	—	1	5	—	—	—	—	2	7	1	4	m-6	2
Carroll.....	—	—	—	—	—	—	—	—	—	—	—	1	—	1	—	—	—	—
Frederick.....	—	—	—	—	—	1	1	6	—	4	—	—	—	3	—	—	m-1	—
Washington.....	—	—	—	—	—	—	—	4	—	—	—	—	—	1	—	2	m-1	3
Allegany.....	—	—	—	—	—	—	—	—	—	1	—	—	1	2	—	—	—	—
Garrett.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	2
Montgomery.....	—	—	—	—	—	—	1	5	—	1	—	—	—	22	—	—	—	2
Pr. George's.....	—	—	1	—	3	—	1	3	—	—	—	—	—	14	—	—	—	1
Calvert.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Saint Mary's.....	—	—	—	8	—	—	—	—	—	—	—	—	—	—	—	4	—	—
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
Kent.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—
Queen Anne's.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Caroline.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—
Talbot.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	4	—	—
Dorchester.....	—	—	—	1	—	—	—	—	—	1	—	—	—	3	—	—	—	—
Wicomico.....	—	—	—	—	—	—	—	1	—	—	—	—	—	4	1	12	—	—
Worcester.....	—	—	—	—	—	—	1	3	—	—	—	—	—	—	1	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Total Counties.....	2	0	4	15	5	1	7	37	0	10	0	1	6	92	5	44		18
Baltimore City.....	4	0	4	5	3	2	22	11	0	7	0	0	7	98	20	691	e-2	13
State																		
Aug. 29–Sept. 25, 1952.....	6	0	8	20	8	3	29	48	0	17	0	1	13	190	25	735		31
Same period 1951.....	36	2	7	9	114	0	29	16	4	20	6	2	14	242	16	706		12
5-year median.....	15	8	4	—	21	4	31	37	7	23	4	2	108	195	76	697		33
Cumulative totals																		
State																		
Year 1952 to date.....	2737	7	833	182	9066	71	915	101	29	838	15	13	165	2079	150	5583		508
Same period 1951.....	2707	33	844	186	5385	44	3579	48	39	728	16	23	354	2048	248	5479		378
5-year median.....	3041	154	384	—	2910	96	1206	95	54	885	26	33	1010	2113	996	5685		515

e = acute encephalitis.

m = malaria; all were contracted outside the U. S. A.

Paralytic poliomyelitis in Maryland seemed to reach its peak this year during the third week of September. More than twice as many cases have occurred to-date as in 1951. Three fourths of these have been in the Counties of Maryland.

In 1950, an epidemic year, there were 256 cases received by September 25th as compared with 101 cases in 1952 for the same period.

BLUE CROSS AND BLUE SHIELD

A PROGRESS REPORT

REGINALD H. DABNEY*

Both Blue Cross and Blue Shield Plans continued to show steady growth in the first six months of 1952, in enrollment, as well as in payments for hospital and medical care which is the real measure of service to the subscribing public. Here are some highlights which should be of interest:—

BLUE CROSS

Membership as of June 30 stood at 857,000 as compared with 842,000 at the beginning of 1952. The rate of increase is slower as the Plan grows larger, but it still continues a steady upward trend.

Much more impressive are the figures on payments for hospital care—\$5,157,900 during the first six months of 1952 as compared with \$3,859,000 in the same period a year ago. This is an increase of 34 per cent, resulting primarily from the increase in hospital costs, and to a lesser extent from increased utilization by subscribers. The average payment for each in-patient case (excluding maternity) has gone up from \$96 to \$133.

BLUE CROSS PATIENTS AND PAYMENTS (First Six Months of 1952)

Subscribers Hospitalized.....	56,426
Total Patient Days.....	328,160
Average Payment per In-Patient Case.....	\$133
Total Payments for All Care.....	\$5,157,900

Subscribers receiving hospital care in the first half of 1952 totalled 56,326, an increase of about 10 per cent over the same period in 1951, and they used (excluding out-patients) 328,160 days of care. Expressed another way, 12 subscribers out of every 100 went to the hospital in the first six months of

this year, while in 1951 only 10 out of every 100 were hospitalized. This increase in utilization—an extension of a basic upward trend since 1946—is cause for serious concern. The average length of stay for the period was 7.6 days, unchanged from a year ago.

BLUE SHIELD

Membership in Blue Shield on June 30 was 172,200, of whom 69,200 were enrolled under our own program and 103,000 under the special contract for Bethlehem Steel employees which was effective September 1, 1951; a year ago there were 46,080 subscribers. Here are the highlights of our own Blue Shield program:—

During the first half of the year 4,338 subscribers received benefits—2,873 of them for surgery, 1,440 for medical care and 339 for obstetrics. In the same period a year ago benefits were provided to a total of only 1,574—about 50 per cent less.

The average payment per case for the first six months came to \$71; the average was \$73 for surgical care, \$53 for medical and \$93 for obstetrics.

Full service benefits were received by 53 per cent of the subscribers whose incomes were under the established limits, while the remaining 47 per cent with higher incomes received benefits as a credit toward the physician's charge.

Payments to physicians in the period totalled \$307,100 as compared with \$104,900 in the first six months of 1951.

Including the special Bethlehem program, payments of \$560,000 were made to physicians on behalf of 5,165 subscribers during the current half year. This amount represented 85 per cent of the total paid in by subscribers under both programs.

* Executive Director, Maryland Hospital Service, Inc., and Maryland Medical Service, Inc.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

PRESIDENT'S MESSAGE

Our Auxiliary is unique in that it is the only organization which is composed solely of the wives of physicians and which exists to assist the Medical and Chirurgical Faculty and to carry out its requests. We support the Faculty by distributing positive health information, by working for good Public Relations for the medical profession, and by helping in the doctor's campaign to preserve our American form of government, fighting socialized medicine. In other words, we are an educational, rather than a service organization.

Just as the Hospital Auxiliaries serve the hospitals and help them to better serve the public, so we endeavor to help the Medical and Chirurgical Faculty. Unlike the Hospital Auxiliaries and other civic groups, however, everyone of our members *must* be a doctor's wife and no other women may join the organization! Naturally, in our Auxiliary, there is always immediate support and understanding of the views of the profession. We learn from the Medical Society, itself, the legal measures which it feels necessary to the health of the community, when the public should be instructed on the needs of medical progress, and which legislation seeks to impose Government Medicine on the people! We not only *want* to help the Faculty to carry out its aims, but, under our Auxiliary Constitution we are required to. In working to assist the doctors we make firm friends among the wives of our husbands' colleagues. Surely every physician's wife will want to do her part in our state-wide and national effort.

As your representative at the June Convention of the Woman's Auxiliary to the American Medical Association, I described the Maryland Auxiliary's Public Relations work, through our Health Booths at State Fairs. The Auxiliaries of other states were favorably impressed and the Pennsylvania Auxiliary has subsequently printed a description of our work at the Timonium Fair of last year, in their Auxiliary Department of The Pennsylvania Medical Journal.

This year, at the request of the National Auxiliary, we are making movies of the setting up and running of our Health Booth at Timonium. The movie will be shown in Chicago at the November Conference, of the Woman's Auxiliary to the American Medical



Mrs. Charles Herman Williams, President
April, 1952 to April, 1953

Association! As such a new member of the National Auxiliary, we are proud of making this contribution to the National Program.

As to program, we realize that our State Auxiliary Program, with its constant flow of letters regarding Civil Defense, Nurse Recruitment, Medical Research, Legislation, getting out the vote, etc., at times seems overwhelming. It may also be annoying to the Component Auxiliary, which has already done more work and knows more on a given subject than

the rest of the state! The thing to remember is that these are only suggestions. Our program is completely flexible and voluntary. Since we do sincerely believe in the American tradition we are a grass roots organization with no dictation from the top down. Many of the ideas sent to you originated in one of our County Auxiliaries, or in some other state and have been so successful that we felt that more people would like to know about them.

In our very small way, we help the Medical Society to carry out its high aims. These aims are the same now as they were when the Faculty was founded in 1799. They are to protect the health of the people against quackery and mistaken "health" fads and to establish and maintain the highest medical standards in both hospitals and schools of medicine. As you know, the A. M. A. and its member societies established standards of sanitation, public health, desirable pure food and drug requirements and policed their own ranks for charlatans. It eliminated the practice of anyone buying a "diploma" from mail order "Medical Colleges," many years before the government made any laws about such things. Today the Faculty is still leading the way, to constantly improve medical practice, teaching, medical care, and to better health conditions for the public. As a member of this Auxiliary you have the opportunity to help them in some of their efforts to do it.

AUXILIARY CONVENTION NOTES

MRS. CHARLES H. WILLIAMS, *President*

At the National Convention of the Woman's Auxiliary to the American Medical Association, held in Chicago in early June, it was emphasized that we are not a service group but an *educational* one, and "an auxiliary to one of the oldest scientific bodies in the world." Dr. Scatliffe called us "an arm of the A. M. A.," Dr. Furey, "an aid to the worthy cause of medicine." If this is not enough definition, did you know that Dr. Louis H. Bauer, President of the A. M. A., has described us as a "tie-in between doctors and their socio-economic problems." Mrs. Kice, Parliamentarian of our national body, describes our auxiliary work for the Future of America in and with all other organized groups as "working together in behalf of humanity." Our Health Educa-

tion Program which already includes such subjects as Medical Research, Narcotics Addiction, Nurse Recruitment, Safety Campaign, and Civil Defense should now include Mental Hygiene. Certain main goals were stressed. Inspiration and encouragement for our new Maryland Auxiliary of roughly three hundred members and with only seven counties organized can be found in the history of the National Auxiliary. National started in 1922 with twenty-eight members, a number which, in 1932, had increased to 14,000, and which by 1942 had become 27,000. Now, in 1952, it totals 60,000 members representing all forty-eight states with 13,000 counties organized.

"Today's Health"

The Massachusetts Auxiliary reported making six thousand dollars by selling "Today's Health" at the public price of three dollars with a profit of a dollar and a half per subscription to the Auxiliary. This double triumph of raising money while furthering our goal of health education was accomplished by putting every Auxiliary member in Massachusetts on the "Today's Health" Committee. All members of the Auxiliary saw to it that the magazine was sold to their own community beauty shop, train station, drug store, baker shop, and as Christmas gifts. Members placed copies which they had purchased at the reduced dollar and a half yearly rate in their local drug store and newsstands in railroad stations, etc., and which were sold at the regular monthly rate to the public, through the voluntary cooperation of their friendly druggist or other dealer. The Auxiliary Legislation Committee sent subscriptions of "Today's Health" to their Congressmen in Washington because of its positive health information and its sympathetic articles concerning the physician. The American Medical Association this year has asked every Auxiliary to make "Today's Health" "No. 1" on its program because it establishes a needed liaison between the doctor and the public!

Funds

The California Auxiliary, which is twenty-eight years old, receives \$5,000.00 annually from the California Medical Society. In Tennessee the Medical Society dues automatically cover Auxiliary membership for each doctor's wife and in addition the Tennessee Medical Society donates fifty cents per mem-

ber to the Auxiliary for its Public Relations and Educational work. May such a day dawn for us, too!

Nurse Recruitment

The number two request to the Auxiliary from the A. M. A. is Nurse Recruitment with emphasis not just on Nursing Scholarships, but also on keeping the nurses whom we have. Suggestions to Nurse Recruitment Committees were to furnish a list graph of all available Nursing Scholarships from any sources whatsoever to Vocational Counselors in schools and to meet the unrest in our young people by counseling them into the Nursing profession, not so much for financial rewards as for satisfaction of human service which are "not taxable," and which are enhanced by working in one's own community. Perhaps the greatest need right now is for Licensed Practical Nursing to furnish bedside care, as well as the three year and the college courses. Since professional recruiters go into high schools from other organizations the Auxiliary should investigate to avoid overlapping, try to reach obscure country or private schools which are *not* covered routinely. Perhaps the Auxiliary can coordinate some of their efforts and help to avoid having any schools receive *separate nursing* appeals from each local hospital. Future Nurses' Clubs can help girls take pride in a high calling, and don't forget that the best "recruiter" is someone whom the student knows! It is the responsibility of a School of Nursing to satisfy the student, first, with an excellent faculty and, secondly, with recreational facilities. The A. M. A. hopes that the Auxiliary will interest themselves in the *improvement of the nursing schools*, since 50 per cent of the students in some states fail their State Board Examinations apparently due to inferior preparation! Application forms for information on nursing schools should be sent to high school principals. "Nurse Recruitment Week" will bring in applications! In California, two doctors, as individuals, contributed \$29,000.00 towards Auxiliary Nursing Scholarships and in Nevada, the Auxiliary netted \$26,000.00 for scholarships by holding a rummage sale.

General Program Helps

The Auxiliary Membership Committee should see that every doctor's wife who is not a member, is

personally contacted and invited to join. In this way Texas acquired two hundred and sixty-two new members last year. It was emphasized that it is even more important to keep old members, really, than it is to make new ones. Therefore, Auxiliary Treasurers should send follow-up letters on all delinquent dues, knowing that many people intend to pay them and simply procrastinate. Old members should always be called and signed up again.

The Archives should be kept active with pictures, biographies and a few well chosen articles bearing on our work.

The A. M. A. feels that Civil Defense is in "bad shape" at present. We are asked to interest lay people in checking their emergency medical supplies, to see that other women as well as our own members are trained in First Aid and participate in Nurse Recruitment.

All President-Elects are urged to "line up" their Chairmen and Officers ahead of time so that they can take over immediately and effectively upon election.

Legislation Committees were urged to visit and really know their Senators and Congressmen, who also can be placed on Auxiliary programs occasionally.

"An ounce of prevention" is a slogan for County Fair Health Booths and for Safety campaigns. More children die by accident in this country than by disease. Use this in your publicity!

We were reminded that for over a hundred years the A. M. A. furnished all of its *services* to doctors without charge, as the "Journal" advertisements met expenses! Now however, it has become necessary to maintain three Washington representatives to convey the doctor's reaction to medical bills.

The Arkansas Auxiliary saw the first Negro woman doctor graduate in their state on money which they had raised four years ago! Another state Auxiliary greets all new citizens when they take their Oath of Allegiance, and other states emphasize the importance of having members join the P.T.A. and such organizations. Since this is election year, we were urged to have appropriate programs. The following is cited as an example program. One Auxiliary's members were notarized to go into hospitals to collect absentee ballots. They also put advertisements in the paper well in advance, to remind students and soldiers to write home for absentee ballots.

The Public Relations Department of the A. M. A. will write an answer to any article you find that is detrimental to medicine. Mail them the article and they will send you a reply based on fact.

A. M. A. Request to the Auxiliary

The A. M. A. asked the Auxiliary through a resolution, to tackle the problem of private support for the Nation's Medical Schools, which showed deficits of from eight hundred to eight hundred thousand dollars, per school, last year. The American Medical Education Foundation is the A. M. A.'s answer to this need and the Auxiliaries as well as the Medical Societies are asked to support it. The Medical Schools, obviously cannot continue to operate while "running in the red." The Federal Government has offered to subsidize the schools but the A. M. A. opposes this and feels that the government, if it pays the bills, could dictate policy and so control Medical Education.

The A. M. A. does not oppose state grants. The National Fund for Medical Education is a lay organization that collects funds from the Medical Profession as well as from lay persons and corporations. It allots money to the Medical Schools at the end of each year. Persons desiring to contribute to a certain school can so indicate on their check and the money will go to the designated school of medicine. A suggestion has been made that each doctor could give at least one dollar for each year that he has practised medicine. So far this year, only a quarter of the necessary money has been collected, with 42 per cent coming from the profession. The Fund collection year runs from January to January. The A. M. A. states that the Auxiliary's place is to "walk beside and to help however it can with the problem!"

* * *

OPEN LETTER TO THE WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY

Ladies:

As Chairman of the Maryland State Committee of the American Medical Education Foundation, I was greatly heartened to hear that the Woman's Auxiliary had been requested by the A. M. A. to lend both their moral and physical energies to the support of the Foundation.

The Foundation represents the physicians' (your husbands') opportunity to contribute to his medical

school in order to maintain it from the government control and domination that accompanies government subsidy.

While we will certainly welcome financial support from the Auxiliary, we will equally appreciate each individual wife's reminder to her husband of his responsibility in this annual campaign.

It is unique that there are no "strings" to this money, since it is privately given. Government grants, must be spent for specific projects, in spite of the fact that medical progress may indicate a different direction for its best use. There is no money wasted raising this money either, and every dollar you give goes directly to the Medical Schools, because the A. M. A. absorbs all of the secretarial expenses, etc. This is the first time that doctors have been asked to support a campaign of their "own," one so intimately associated with their interests, backgrounds and with the future of the profession, the needs of which are closer and more apparent to them than any layman.

Laymen are supporting the American Medical Education Foundation just as generously as doctors have always supported Religious, Educational and Civic drives. As most doctors realize, their own medical educations were not really paid for entirely by tuition fees, since medical schools have leaned heavily on endowments now taxed out of existence by government. This is a real case of "pulling ourselves up by our boot straps."

Any support which the Auxiliary member can give and also influence her husband to give will be a great help and, of course, the formation of whatever Committees are deemed necessary by the Auxiliary itself, will all assist our common cause. Our State Committee for the American Medical Education Foundation looks forward to happy and productive teamwork on our program with your Auxiliary!

With best wishes, I am

Sincerely,

NEWLAND E. DAY, M.D., Chairman
State Committee to Cooperate with
American Medical Education Foundation

* * *

AUXILIARY NEWS

Mrs. Charles H. Williams, President has announced the following appointments as State Auxiliary Chairmen:

Special Committees, Mrs. R. Walter Graham, Jr.,

Medical Research; Mrs. Edwin H. Stewart, Jr., Co-Chairman; Mrs. E. Irving Baumgartner, Civil Defense; Mrs. Hammond J. Dugan, American Education; Mrs. Martin E. Strobel, Narcotics Addiction; Mrs. W. Kenneth Mansfield, Nurse Recruitment; Mrs. Beverley C. Compton, Creative Arts Show; Mrs. S. Jack Sugar, Membership; Mrs. George E. Urban, Convention Arrangements; Mrs. George H. Yeager, Auxiliary Editor; Mrs. J. Carlton Wich, American Medical Education Foundation.

Standing Committees, Mrs. E. Ellsworth Cook, "Today's Health"; Mrs. H. Hanford Hopkins, Legislation; Mrs. Thomas A. Christensen, Organization; Mrs. John G. Ball, Public Relations; Mrs. A. S. Chalfant, Program; Mrs. Elliott E. Flick, Finance; Mrs. Harry Davies, Historian; Mrs. Amos R. Koontz, Revisions and Resolutions; Mrs. Gerald W. Le Van, Doctor's Day; Mrs. George H. Yeager, Press and Publicity; Mrs. Omar D. Sprecher, Jr., Bulletin; Mrs. James T. Marsh, Members-At-Large.

We are very proud to state that at least five Auxiliaries manned Health Booths at County Fairs this summer and used the exhibits prepared for us by The Maryland Society for Medical Research.

Mrs. George H. Yeager has been made National Public Relations Chairman for the Eastern Regional by the Woman's Auxiliary to the American Medical Association.

THE TIMONIUM FAIR HEALTH BOOTH—1952

This year, the Health Booth at the Timonium Fair was really the joint project of the Auxiliary to the Baltimore County Medical Association, The Baltimore County Medical Association, itself, and the Baltimore City Auxiliary, with assistance from the Medical and Chirurgical Faculty and the State Auxiliary. The Baltimore County Medical Association felt that the Health Booth in the past had been a valuable aid in public relations and therefore made sure of its 1952 success by financial assistance towards expenses, by advice, and by the donation of time and hard work. The Society was able to solve problems which had baffled the Auxiliary. Cooperation with other organizations interested in health, such as the Maryland Society for Medical Research, The National Guard, the School of Nursing of the University of Maryland, the Baltimore County Fire Department and even with individuals who volun-

teered their services, made the Booth a real community effort and a *living example* of good Public Relations for the medical profession.

Our State Auxiliary President, Mrs. Charles H. Williams, gave a tremendous amount of time and effort towards the setting up and running of the Booth as did Dr. Williams, who is President of the Baltimore County Medical Association. (Our "Famous Family!") Mrs. Martin Strobel, President of the Baltimore County Auxiliary, appointed Mrs. D. Delmas Caples to secure members to man the Booth at night, while Mrs. Albert E. Goldstein, President of the Baltimore City Auxiliary, appointed Mrs. H. Melvin Radman to organize members for the day time hours of the eleven day Fair.

The front of the Booth was made attractive by the electrical question and answer exhibit of the Maryland Society for Medical Research and by the foot high dolls in Nurse's uniforms, a "graduate" and a "student," which were supplied by the School of Nursing, the University of Maryland. Real nurses, from the same School, gave free blood pressure readings to the public. Groups of teen-age girls clustered about eyeing the uniformed dolls, admiring the pretty nurses and reading Nurse Recruitment literature. Medical Research literature was also distributed along with A. M. A. pamphlets such as "A Doctor For You" and "Your Money's Worth in Health."

Free educational movies were shown in a tent behind the Booth and including "Frontiers In Medical Research" and a very popular animated cartoon on the same subject called "Man's Greatest Friend," another cartoon on diet called "Winning to Lose," one called "Catching a Cold," a heart film, and the "hit of the show," an animated picture exposing the evils of socialism called "The Foxes Will Get You If You Don't Watch Out." This last one came from the Metropolitan Life Insurance Company, whereas most of the films of ten minute average duration, came through the Woman's Auxiliary to the A. M. A., 535 North Dearborn Street, Chicago 10, Illinois. The short, amusing films were the most popular and two movie projectors and operators were employed simultaneously so that one reel of film could instantly follow another and one film could be rewound while the other one was being used.

The Health Booth this year was not only a wonderful success but the heart warming cooperation of the Medical Societies with the Auxiliaries and of

both with other health organizations, civic groups, and individual citizens demonstrates the best relations as existing both within and without our ranks and a most happy health achievement for all of the community.

AUXILIARY NEWS

Mrs. Joseph Carlton Wich has been appointed State Auxiliary Chairman for the American Medical Education Foundation. Our representatives, or liaison with the Woman's Auxiliary to the Southern Medical Association are Mrs. Frederick A. Holden and Mrs. Thomas A. Christensen, Past President of this Auxiliary. Three Resolutions derived from Maryland were passed by our National Auxiliary at the June Convention—one on Americanism, one on Safety, and one on keeping Auxiliary Membership lists private. Other National Resolutions favored

Voluntary Health Insurance Programs, more leaflets on A. M. A. Services, continuance of Civil Defense Programs, continuance of Blood Donor Programs, encouragement of members to run for legislature, School Board, and other government positions, sponsorship of the Program of the National Association for Practical Nurse Education, the registration and vote getting campaign for medical families, sponsorship of Urban and Rural Health Days and the sponsorship of good medical research legislation.

CIVIL DEFENSE WARNING

It was learned at the June Convention that Civil Defense must have more doctors or it cannot function! Has your husband offered his services? The A. M. A. warns us that the alternative to Civil Defense is Martial Law!



DOCTOR, TAKE THIS HOME TO YOUR WIFE!

SUPPORT OUR MEDICAL SCHOOLS! HELP US TO FOUND A NURSING SCHOLARSHIP!

Join us at the Benefit Dessert Bridge Fashion Show, a very complete showing of new fashions by Hutzler Brothers, on Wednesday, November twelfth, at one o'clock, in the Medical and Chirurgical Faculty Building. Tickets are \$1.25. Call Mrs. E. Ellsworth Cook, at BELmont 7887 for tables.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

SILVER SERVICE NEEDED

The Woman's Auxiliary would very much appreciate the donation of a silver service for use at buffet luncheons and teas at the Medical and Chirurgical Faculty Building. Two services really are needed and the suggestion has been made that they might be given, possibly as a memorial. The doctors could make use of them also. Sandwich trays, bon-bon dishes, flower bowls and candelabra would be a most welcome addition. Have you inherited any silver of this type which you do not need?

Ancillary News

DENTAL SECTION

BALTIMORE CITY HEALTH SOCIETY

A. BERNARD ESKOW, D.D.S.

Journal Representative

Despite the fact that the summer season finds no regular meetings for the dental society, the various committees nevertheless are busily engaged in preparing for the 1952-53 schedule. The monthly scientific meetings committee, under the direction of Dr. K. V. Randolph, are arranging for the usual monthly scientific sessions. The All-Day Meeting Committee, under the direction of Dr. Leon Seligman, is in the process of contacting the necessary clinicians for this session in February.

The Baltimore City Dental Society, during the summer months, joined the other civic groups and under the direction of our President, Dr. Arthur S. Wheeler and the President of the Maryland State Dental Association, appointed Dr. J. Ben Robinson chairman of a committee to aid the Mental Hygiene Society in their current drive. The dental society, taking full cognizance of its responsibility as a member of the allied health professions, contacted each and every member with both a plea as well as an explanation of both their civic and professional responsibilities to this cause.

The semi-annual state meeting at which the Baltimore City Dental Society was the host, was held from Sunday to Tuesday, September 21st-23rd, at the Lord Baltimore Hotel and proved to be a tremendous success. The affair consisted of a reception and cocktail party on Sunday evening and on Monday morning the scientific session was held and instead of the usual pattern of two scientific papers being read, the entire morning was devoted to a panel discussion on "Your Problems in Dentistry"

and was discussed by the following clinicians with Dr. E. D. Lyon of Baltimore, acting as moderator: Dr. E. B. Nuttall, University of Maryland Dental School, Baltimore, Maryland; Lr. Muller DeVan, Philadelphia, Pennsylvania; Dr. Gustav Kruger, Washington, D. C.; Dr. Carlos Weil, Drexel Hill, Pennsylvania. The scientific panel was arranged by the chairman of the scientific sessions for the meeting, Dr. Irving Abramson and his committee. The evening was a dinner-dance under the arrangement of Dr. Leon Seligman, chairman of the social committee. The wives of the members were entertained at an afternoon luncheon and fashion show at the Sheraton-Belvedere Hotel, under the guidance of Mesdames B. Ralph Hoffman, A. S. Wheeler, H. Van Natta, co-chairmen. On Tuesday the members engaged in varied outdoor activities such as golf at Rolling Road Country Club under the direction of Dr. A. Lazarus, chairman of the golf committee, and fishing from Annapolis under the guidance of Dr. L. Smyth, chairman of the fishing committee. This meeting was arranged by the Semiannual Meeting Committee, of which Dr. A. Bernard Eskow is the Chairman.

And finally, as we go to press, as is true with all other organizations, the full scientific sessions are getting under way with the regular monthly meetings.

From all indications, having discussed the coming season with the chairmen of the various committees, this season, under the presidency of Dr. Arthur S. Wheeler, promises to be a most stimulating and favorable one.

At this time a great many of the members are making plans to attend the annual meeting of the American Dental Association, which this year comes in the very early part of September and is being held in St. Louis.

"Vote As You Please—But Please Vote November 4th."

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Administrator*

Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations

MARYLAND PUBLIC HEALTH NURSE WINS ROBERTS FELLOWSHIP

The Fellowship Award Committee of the American Journal of Nursing Company has announced the selection of Anne Rice, R.N., Supervisor of Public Health Nurses of the Baltimore County Health Department as the winner of the 1952 Mary M. Roberts Fellowship Award.

The Fellowship, one of the most coveted prizes open to professional nurses, was established in honor of Miss Mary M. Roberts, distinguished editor emeritus of the American Journal of Nursing, in recognition of her invaluable contributions to the nursing profession over the past half century. Purpose of the fellowship is to assist qualified nurses to acquire and develop writing skills so that they can better interpret nursing to nurses, prospective nurses and the general public in both professional and lay publications, a cause for which Miss Roberts labored for so many years.

Competitors for the award are judged on their general professional qualifications, interest and facility in writing and an evaluation of a specially prepared manuscript on some phase of nursing. Miss Rice's winning manuscript was entitled "Geriatrics and I."

Born in Kentucky, Miss Rice holds a bachelor of arts degree from Western Kentucky State Teachers College and taught school in that state for seven years. She then attended the Washington University School of Nursing in St. Louis, Missouri and, after receiving her bachelor's degree from that institution, continued her studies at Columbia University where she was awarded her master's degree.

The winner of the 1952 Fellowship has been registered and practiced nursing in the states of Missouri, Kentucky, Tennessee, Ohio and Maryland. Presently employed as Supervisor of Public Health Nurses, Baltimore County Health Department, Towson, Maryland, Miss Rice was formerly Senior Staff Nurse of the Defiance County Health Department, Defiance, Ohio and, prior to that, a staff nurse with the

Oak Ridge Tennessee Department of Public Health.

Under the terms of the grant, the winner is awarded between \$3,000 and \$4,000 to defray the expense of a year's study in education and journalism at a recognized college or university. While she is free to select a school of her own choosing the proposed course of study requires approval of the committee and must include courses in writing. Miss Rice has announced she is arranging for a leave of absence from her position with the Baltimore County Health Department and will enroll this fall at Teachers College, Columbia University, New York.

NURSING SERVICE STAFFING FOR THE NEW VETERANS ADMINISTRATION HOSPITAL IN BALTIMORE

Whenever new Veterans Administration Hospitals are opened concern is usually felt locally about the effect the nursing service staffing of these hospitals will have upon the nursing staffs of other hospitals in the area. We have been informed by Miss Dorothy V. Wheeler, Director, Nursing Service, Veterans Administration, that the new Veterans Administration Hospital in Baltimore is tentatively scheduled for activation in October 1952. Miss Wheeler, recognizing the probability of local concern, has sent to the Maryland State Nurses Association a statement of general policy relative to plans for the nursing service staffing in this hospital. We believe the physicians of Maryland will be interested in this policy and we are glad to share with them the information which Miss Wheeler has sent us.

The following is an excerpt from Miss Wheeler's communication:

"We wish to emphasize that it is our policy to do everything possible to avoid depleting the staff of local hospitals by giving first consideration to requests for transfer from nurses already in our service, and by referring nurse applicants from various parts of the country. We do not solicit applications locally and refrain from active

recruitment in the local areas. However, we are obliged to accept applications and to give equal consideration to local applicants.

"When the Manager and Chief, Nursing Service, of a new Veterans Administration hospital are assigned, it is our intent that they will contact and coordinate employment of local nurses with the Directors of Nursing at the various local hospitals. In the event a number of nurses have made application, and are currently employed in a particular local hospital, and are determined eligible for appointment in our service, every effort will be made by our organization to space the dates of acceptance for employment in such a manner as to place a minimum amount of inconvenience on the local hospital which is losing nurses.

"The Chief, Nursing Service and the Assistant Chiefs both in Nursing Service and

Nursing Education have been selected for the new Baltimore hospital. These nurses are all currently employed in our service. It is anticipated that, insofar as possible, other administrative and supervisory nurse personnel will also be nurses currently employed in Veterans Administration, who have requested transfer.

"Our new hospitals are activated slowly, usually with a nucleus of nurses transferred in from other Veterans Administration hospitals. It will doubtless be several months and on a gradual basis before an appreciable number of new nurse applicants are employed."

Miss Margaret Greene is scheduled to report for duty as Chief, Nursing Service of the new Veterans Administration Hospital in Baltimore the latter part of August. Miss Greene, whose home is in Baltimore, is being transferred from a similar position in Portland, Oregon.

PHARMACY SECTION

Maryland Board of Pharmacy

L. M. KANTNER, PHAR.D., *Secretary*

THE AMERICAN PHARMACEUTICAL ASSOCIATION CELEBRATES 100th ANNIVERSARY

In the City of Philadelphia, where the American Pharmaceutical Association was organized in 1852—just five years after the founding of the American Medical Association, pharmacists and representatives of allied professions from twenty-two foreign countries met during the week of August 18th, celebrating a century of progress in professional pharmacy, education, and cooperation with the healing professions.

Claim is made that 15,000,000 people visit the pharmacies of the United States every day. Many of the people come to make purchases totally unrelated to medical care. Thousands of others go to

the pharmacy to have prescriptions filled and to procure the various needs in medical care.

In 1852, the pharmacist was required to be a manufacturer of the preparations he dispensed on prescriptions or supplied to the physician who oft times carried his medical supplies in saddle bags.

The pharmacist made his fluid extracts, tinctures, infusions, decoctions, pills, ointments, and plasters. There were no drug laws that necessitated a medicinal to meet definite standards.

Assays for his products were unknown, and despite the meticulous care exercised in the manufacturing of medicinals, at the best, it was a more or less hit or miss procedure.

Today, medicinals must meet definite standards for purity and strength, and the industry is policed by Federal and State authorities.

In 1852, narcotics could be sold as freely as Bicarbonate of Soda. Soothing syrups and cough mixtures were loaded with opium or morphine, and catarrh powders were fortified with Cocaine. A century and less ago, leeches were an item that could be obtained in a large number of the drug stores—and, it is claimed the sale was most heavy on Sunday morning—"the morning after the night before."

Today, there is but one drug store known to the writer where leeches are procurable.

Pharmacists were trained by the preceptor system and often the parent paid the pharmacist (many of whom were educated in Europe) to permit the son to enter the establishment as an apprentice.

In those days, women pharmacists were unknown. Today, 5% of the pharmacists are women. Many of these are found in hospital pharmacies.

Today, about 5% of the pharmacies are strictly professional, excluding all activity to the filling of prescriptions and supplying medical care supplies.

Although the Philadelphia College of Pharmacy was established in 1821, there were no educational requirements to practice pharmacy. Since 1920, the pharmaceutical educational standards have been raised from a two year college course to a full academic course of four years, placing pharmacy on the same footing with all other branches of science taught at institutions of higher learning. Some of the present day Colleges of Pharmacy have extended the course to six years, leading to the doctor's degree.

Today, there are hundreds of millions of dollars invested in pharmaceutical manufacturing plants, many of which developed from a former retail drug store: Sharp and Dohme, Wyeth, Eli Lilly, and others. In these structures of steel, brick and concrete, roughly 65,000-75,000 pharmacists are employed as manufacturers of special preparations, chemists, assayists, bacteriologists, biochemists, detail representatives, as well as executives.

These pharmaceutical manufacturers are supplying the medical profession with drugs that have a dramatic curing effect. Claim is made that 80% of today's effective medication was unheard of 20 years ago. Poke, root, sumbul, valerian, taraxicum, uva ursi, buchu, to mention a few, are gone with the times.

Specialized medicine is the order of the day. These drugs are released for consumption only after the most painstaking care conceivable to man to assure as perfect a product as is humanly possible to produce. From the standardization of raw materials, all operations are under perfect aseptic and sanitary surroundings. Laboratory tests, chemical or biological, then clinical tests—all this to give assurance of perfect medication—for specific purposes.

Dr. Howard A. Rusk, writing in the *New York Times* says:

"The 'drug store' is a peculiarly American institution. It combines the elements of the English 'chemist shop' and the European 'apotheker' and 'drogagerie,' of providing a convenient source of supply for health requisites, with a broad gamut of services and articles that have nothing to do with medical care. As one leading pharmacist said: 'What the American public has actually done is to subsidize its pharmacies for emergency needs by patronizing them for merchandise quite unrelated to the business in drugs or the practice of Pharmacy. They want pharmacies available at convenient spots when, as and if needed for professional—services.'

"Backing up the contributions of the corner drug-store pharmacist are the tremendous programs of drug manufacturing, drug standardization and control, research and development of the country's pharmaceutical industry. They bear the responsibility of bringing the results of test tube discoveries to the bed-side at a cost within the reach of the average citizen."

"Standing by as government 'watchdogs' to insure quality and purity are the Biologics Control Unit of the National Institutes of Health and the Federal Food and Drug Administration. However, as Surgeon General Leonard A. Scheele has pointed out, 'Although authority to enforce biologic standards is vested in the Public Health Service, there has been little occasion to use authority. Instead, the industry and the Service have recognized a mutual interest in and responsibility for protecting the public against impure or inferior biologic products.'"

"On this, its one hundredth anniversary, the American Pharmaceutical Association merits the congratulations of the public and the professions that it serves."

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EDITORIAL¹

STATUS OF CHLORAMPHENICOL THERAPY

THEODORE E. WOODWARD, M.D.²

Chloramphenicol is the most recent chemotherapeutic agent to arouse suspicion for deleterious effects upon man. Certain disorders of the hemopoietic system, particularly aplastic anemia, thrombopenia and pancytopenia, are said to have resulted from the ill-advised and indiscriminate use of this valuable drug. Chloramphenicol, therefore, must be listed with other useful agents such as the sulfonamides, amidopyrine and the arsenicals which have been shown to provoke undesirable side reactions, although their actual human hazard is not yet known. Moreover, penicillin and even acetyl salicylic acid are not without a certain risk.

Chloramphenicol, an antibiotic produced by fermentation and synthetic methods, possesses a nitrobenzene radical as its basic structure which is known to exert depressing effects upon the bone marrow under certain conditions. From the debut of its clinical trials, this potential hazard was realized and it was furthermore stressed that this antibiotic, like all potent drugs, should not be used promiscuously or indiscriminately, but for specific indications, for short periods of time, until cure has ensued and for a short time thereafter. Unfortunately, chloramphenicol has been much too widely employed, often without specific indication and it is undeniable that certain blood reactions have resulted from its use. Recent alarming reports in various periodicals led to a nationwide survey which was conducted by investigators of the Food and Drug Administration. It became apparent that blood disorders occurred in patients who received the antibiotic, usually repeatedly and for minor illnesses, often in patients with an allergic background. Notable among the patients who developed undesirable side reactions were physicians, relatives of physicians, nurses, pharmacists and technicians who made a practice of munching the capsules for varied non-indicated reasons. Moreover, this investigation uncovered a larger group of patients who contracted similar serious disorders of the hemopoietic system in whom chloramphenicol was *not* employed but rather other currently used chemotherapeutic drugs.

It might be of interest to the readers, particularly those unduly alarmed in Maryland, to read resolutions the National Research Council recently adopted on the recommendation of a special study group.

1. "Certain cases of serious blood dyscrasias (aplastic anemia, thrombocytopenic purpura, granulocytopenia and pancytopenia) have been associated with the administration of chloramphenicol."

¹ Recent publicity with reference to the use of Chloramphenicol Therapy seems to have been out of proportion to the problem. For that reason, Dr. Woodward has been requested by the Editor to clarify the issue.

² Associate Professor of Medicine, University of Maryland School of Medicine.

2. "Although this complication has thus far been uncommon, it is sufficiently important to warrant a warning on the label of packages of the drug and in advertisements of the drug and the recommendation that chloramphenicol not be used indiscriminately or for minor infections."
3. "When prolonged or intermittent administration is required, adequate blood studies should be carried out."
4. "In view of the paucity of information at the present time, the Conference hopes that further study of serious reactions to chloramphenicol and other drugs will be promoted. The records of the Veterans Administration and military forces could be of great value in providing some of the desired information."

The natural forces of immunity usually arrest the course of events in minor illnesses. When it becomes necessary to employ drugs in more serious infectious diseases the chemotherapeutic agent should be considered only as a supplemental aid to the more basic mechanisms of healing. Chloramphenicol, not unlike other valuable antimicrobial drugs, may be given with a certain calculated risk and certainly never as a therapeutic panacea.

AMERICAN MEDICAL EDUCATION FOUNDATION

Hiram W. Jones, Executive Secretary

The National Fund for Medical Education will make a Class "A" grant to each of the seventy-nine medical schools in the United States on July 31, 1952.

Class "A" grant amounts to \$15,000.00 for each four-year school and \$7,500.00 for each two-year school. The total amount to be distributed will approximate \$1,132,500.00

The following report of the Reference Committee on Medical Education and Hospitals was unanimously adopted by the House of Delegates of the American Medical Association on June 11, 1952:

Your Reference Committee commends the excellent report of Dr. Henderson, President of the American Medical Education Foundation. Your Reference Committee believes that the American Medical Education Foundation deserves and should have the unqualified support of all members of the American Medical Association. Many of the constituent state medical societies have set up committees for the collection of funds from their members in addition to making a substantial contribution to the Foundation from their own funds. Your Reference Committee urges that similar committees be formed in the state societies where this has not been done. The large sums collected by some state and county medical societies is an indication of what can be accomplished when the importance of this laudable undertaking is brought to the attention of each individual member of the Association. Your Reference Committee believes that those who adhere to the basic concepts of democracy should support the tenets of democracy not only with words but with deeds.

Respectfully submitted,

Edgar V. Allen, M.D.
Charles H. Phifer, M.D.
John J. Masterson, M.D.
Charles G. Hayden, M.D.

SPECIAL CURRENT NOTICES

STATEWIDE STUDY OF PREMATURE INFANTS—THE GESELL DEVELOPMENTAL EXAMINATIONS

Following is a letter dated October 2, 1952, which was received by Dr. George H. Yeager, Secretary of the Medical and Chirurgical Faculty:

This is an open letter to thank the physicians of Maryland for their cooperation in the statewide study of premature infants and to describe the Gesell developmental examinations which will start during October.

You will recall that this study is being undertaken by the Division of Maternal and Child Health of the Johns Hopkins University with the endorsement of the Medical and Chirurgical Faculty and other groups. In accord with plans previously announced in the State Medical Journal and in letters to each physician in the state, the developmental examinations will be limited to about 500 prematures and an equal number of full-term babies in Baltimore City. The plan is to follow these two groups into their school years to determine if the prematurely born infant has an equal chance of developing normally or, if not, what are his handicaps and what can be done to prevent or lessen them.

It is clear that the use of representative groups is essential to validate a study of this sort. In order to get such groups, the babies for this part of the study will be selected automatically on the basis of such criteria as race, place of residence, and place of birth. Since only about 500 prematures and 500 full-term control babies can be followed, it is clear that most physicians will have only one or two babies in this part of the study. The importance of the controls cannot be emphasized too much. We realize that occasionally a patient of yours who presents a special

problem will be among those automatically selected. Please let us know if there is any information about such a patient which you wish us to have. We assure you that we will do everything in our power to make the visit of your patients pleasant and worthwhile.

The Gesell examination will be the first step in the long time follow up study. It will be for diagnosis only; the information obtained will be confidential and a report will be sent to the child's physician. The infant's parents will be referred to their physician for all advice.

A letter will be sent to the physician and to the parents of each premature infant and of each control who is selected for this part of the study. These letters will describe the examination and will assure the parent that the visit to the Study Center on Rutland Avenue will be pleasant and will appear to the baby to be a matter of playing with toys. Family physicians will be cordially welcome at the examination of their patients if they wish to attend.

In closing, I would again express appreciation for the extraordinary cooperation with the first part of the study. We already have received the forms on over 3,000 babies which is more than 90% of the prematures born in Maryland during the first nine months of this year.

Sincerely yours,

PAUL HARPER, M.D.
THE JOHNS HOPKINS UNIVERSITY
SCHOOL OF HYGIENE AND PUBLIC
HEALTH
615 North Wolfe Street
Baltimore 5, Maryland

Scientific Papers

SYMPOSIUM ON THE USE AND MISUSE OF BLOOD TRANSFUSION IN SURGERY¹

DR. I. RIDGEWAY TRIMBLE, CHAIRMAN: First of all we are indebted to Dr. Kimberly and his program committee for this very interesting program he has arranged tonight. We are particularly glad to welcome Dr. Allen from Chicago and our own Dr. Conley, both of them are authorities on their subjects, and I'll introduce them as they appear on the program.

Dr. J. Garrott Allen is a Professor at the University of Chicago, is a graduate of Harvard Medical School, Class of 1938; originally comes from Elkins, West Virginia. After graduating from Harvard, he went out to the University of Chicago and has been in Chicago since that time and is now serving on the staff of Dr. Lester Dragstedt, who is Chairman of Surgery there. Dr. Dragstedt succeeded the late Dr. Phemister. Most of you know Dr. Phemister died suddenly the last part of December and all of us here wish to express our deepest sympathy to Dr. Allen and to the University of Chicago in the tragic loss of this great man. Dr. Allen is a general surgeon interested in general surgery and vascular surgery and interested in the blood in particular in all its stages. He won a medal, as many of you know, at the

AMA meeting in 1948. He has been interested in Vitamin K and prothrombin and liver function, among many other things.

He has time—as somehow everyone seems to have out there—to pursue experimental work as well as to do regular work, something we'd like to see more of here and all other places. We, who are busy seem to pursue limited objectives. We don't have time to think as much as we should. The people who are really contributing to medicine and to all its branches are the ones, as we reflect over the years who spare a little time in which they can think and take inventory, something that we sadly lack. I don't know how he does it because he is so busy in his general surgical work as well as experimental work. I know Dr. Allen was also interested in radiation injury and worked a lot on that in the war, a subject which of course is of paramount importance at the present time.

It is a great favor of him to come here; he is one of the most outstanding of the younger surgeons in the country at the present time, and it gives me great pleasure to introduce him, Dr. Allen.

POOLED PLASMA AND HOMOLOGOUS SERUM JAUNDICE²

J. GARROTT ALLEN, M.D.

Many of the recent advances in surgery have been made possible through the proper use of blood and plasma transfusion. Full appreciation of the therapeutic value of these fluids in surgery was not realized until the pioneering work of Doctor Blalock of this city and Doctor Phemister of Chicago became generally known. As with

all therapeutic agents, however, some of the limitations and consequences of the administration of blood and plasma did not become apparent until considerable clinical experience had evolved. One of these I wish to relate tonight.

There are few segments in medical history more intriguing, both in folk lore and in fact, than is the history of blood transfusion. No important progress in this field was possible before Harvey's discovery of the circulation in 1616 and 1628. Shortly thereafter Lohr provided the first documented evidence of transfusion, transfusing blood from one dog to another. Lohr's initial

¹ Presented before a joint meeting of the Baltimore City Medical Society and the Section on Surgery, on Friday, February 15, 1952, at the Medical and Chirurgical Faculty Building, 1211 Cathedral Street, Baltimore 1, Maryland.

² This paper was given before the Baltimore City Medical Society under the title, "The Cause and Prevention of Homologous Serum Jaundice."

experiments gave evidence of unusual insight for his day into the problems of the hydrodynamics of the circulation. Before transfusing his dogs, he withdrew from the recipient animals a volume of blood equal to that which they were to receive. His experimental observations were immediately applied to man, where in a period of five years, so much difficulty was encountered, including fatal reactions, that transfusions were shortly prohibited by law both in England and France. During the next two-hundred and thirty years transfusions were surreptitiously administered on occasion with frequent disastrous results that were sporadically interspersed with enough dramatically beneficial ones to keep alive an active interest in the field. Reactions remained the rule rather than the exception as indicated in a remark by Doctor Halsted. In his first surgical paper written in 1883 on the subject of monoxide poisoning, he described such a transfusion reaction as "The usual post-transfusion rigors lasted for half an hour." (1). Such reactions were tolerated as characteristic of the procedures and in many instances were pyrogenic in nature. But the frequency of fatalities incurred was sufficiently impressive that the fear of transfusions was not easily overcome by Landsteiner's immortal work of 1901 which laid the background for the typing and cross-matching procedures making blood transfusions a safe clinical procedure some ten years before his principles were applied. Landsteiner's second great contribution to this field came about nearly forty years later, when he described the Rh factor. The broad clinical applications of the contributions of Harvey and Landsteiner are probably not exceeded, if indeed equalled, by any other contribution to mankind in medicine.

Another milestone in the development of blood transfusion was the introduction of sodium citrate as an anticoagulant which was to make transfusion a leisurely and orderly procedure. Huston, Lewisohn and Agote, all as independent observers, reported on citrated blood transfusion

within a period of a few months in 1914 and 1915 (2). These observations eventually led to the introduction of banked blood and made possible transfusions of plasma. Once these major problems were overcome, the risk of blood and plasma transfusions was largely abolished, and these fluids became routine in treatment of shock, malnutrition and certain types of anemia.

In the middle of World War I Rous and Turner (3) recognized the importance of preserving blood for prolonged periods of time in order that it could be stock-piled for the war emergency. These investigators and Robinson (4) found that citrated blood could be preserved for nearly a month when glucose was added. Their reports, however, lay dormant for twenty-two years when this problem was re-investigated by the DeGowin (5) and others.

Because plasma can be stored indefinitely in the lyophilized state in contrast to whole blood, plasma became the fluid of choice for stockpiling in event of emergency need. Attesting to its success are the fifteen million units of plasma prepared during World War II. As a matter of production expediency, plasma from many donors was pooled and then redistributed into smaller units suitable for human use. Although none denied the beneficial effects of plasma administration in the treatment and prevention of shock, out of this vast experience came the recognition of a virus disease transmitted by plasma transfusion—*homologous serum jaundice*. The reported attack rate of homologous serum jaundice following the administration of pooled plasma has ranged between two and twenty per cent of patients transfused. The attack rate of homologous serum jaundice continues to persist within this range to date. All attempts thus far to kill the virus in plasma have failed. Among the methods tried without success have been the exposure of plasma to ultraviolet light, ionizing irradiation and to the chemical action of the nitrogen mustards. Because this problem remains unsolved and because of the serious con-

sequences of homologous serum jaundice, plasma has fallen into disrepute and is used only as an emergency measure when blood is not readily available in the treatment of shock.

The attack rate of homologous serum jaundice following blood transfusion is much less than that experienced for pooled plasma. For blood, the incidence ranges between 0.1 and 0.5 per cent. The reason for the increased attack rate for plasma is related to the practice of pooling. The virus carrier rate among the population at large is such that approximately one donor of every one hundred and fifty carries the disease. Consequently, the larger the pool of plasma, the greater the possibility that one donor may be a carrier of the virus and that his plasma will contaminate the entire pool. Therefore, it has been recommended that the donor population of pooled plasma not exceed five. In event of emergency, vast amounts of plasma will be required and large pools will have to be employed to expedite production. In such an event, the benefits of plasma outweigh the hazards of the complications of homologous serum jaundice.

At the University of Chicago Clinics, we have not observed homologous serum jaundice in our patients receiving plasma that could be attributed to the administration of our own plasma. We have, however, recognized this complication following the administration of blood transfusions in twenty-six patients. An analysis of these data have been presented elsewhere (6). This experience has differed from those of others who have reported the attack rate of homologous serum jaundice from pooled plasma transfusions to be ten to fifty times greater than that of blood. We recognized this disparity of experience in 1947 and sought an explanation. A number of questions had to be answered before our observations could be accepted as valid and a plausible explanation offered. In the first place, because homologous serum jaundice does not usually develop until after the patient has left the hospital, it was essential to establish that patients re-

ceiving our pooled plasma had not developed latent jaundice. In consequence, more than 5,000 patients' records were screened to determine their fates. It was also necessary to establish firmly that in those patients who developed latent jaundice, the disease was homologous serum jaundice and not the jaundice of extensive malignant disease, cirrhosis, etc. Two criteria proved helpful: (1) histologic study of liver tissue obtained by needle or surgical biopsy or at autopsy, and (2) the clinical syndrome of hepatitis with jaundice in which the patient spontaneously re-

TABLE 1
Exposure Data

	No. Patients Transfused	Total No. Exposures	Average No. Donors Pt. Exp. To
Blood Only.....	7,893	28,549	3.6
Blood and Plasma.....	726	13,490	53.0
Plasma.....	234	9,860	44.0

covered. Excluded from our series were patients who developed jaundice which progressed until death and whose jaundice was proved to be malignant disease or cirrhosis as established by operative or autopsy findings. The syndrome of so-called "subclinical" homologous serum hepatitis without jaundice was excluded because of its nebulous and ephemeral character. Proceeding on these grounds, the information tabulated in Table 1 appears to validate our impression that patients receiving our own plasma did not develop this disease.

Seeking an explanation for our apparent good fortune, our attention focused upon the method of preparation of plasma as employed in our blood bank. From the beginning of our blood bank, the plasma we prepared was stored in a liquid state at room temperatures ranging between 26° and 35° C. for three months or longer before use. This procedure was employed because we were unable to secure a deep freeze apparatus at the time our blood bank was instituted in September of 1942. The time interval was chosen

because under these conditions there is considerable deterioration in the titre of iso-agglutinins, a desirable situation in minimizing plasma reactions. Under these conditions of plasma storage, the product proved suitable and safe for the prevention and treatment of shock and malnutrition. Undoubtedly plasma, under these conditions, undergoes certain physical and chemical changes when stored indefinitely at room temperature in the liquid state. Whatever these changes may be, clinical experience proved them to be of little significance over this three-year period.

An analysis of the reports on homologous serum jaundice from pooled plasma as they appear in the literature, discloses that in every instance the disease had been produced by plasma stored in the lyophilized (dried), frozen or refrigerated states. Often such data were not contained in the report and had to be obtained by correspondence with the author. It should be stressed, however, that few if any other blood banks employed the room temperature storage of liquid plasma during this same period of time, so that an evaluation of our data in the light of those of others is not yet warranted. However, it should also be pointed out that we, like others, were forced to discontinue the use of "war surplus" dried plasma because of the high incidence of homologous serum jaundice we encountered.

Why should the storage of liquid plasma at room temperature for three months or longer apparently avoid complication of homologous serum jaundice? Again with no personal background of information pertaining to the survival rates of viruses, a search of the literature pertaining to thirty-three viruses known to be pathogenic for man was undertaken in the hope the resistant qualities to these various methods of storage might suggest an answer to our observations. In every instance in which information was available for a particular virus, lyophilization, freezing or refrigeration favored

prolonged virus survival (Table 2). Storage at room temperature and at a liquid cell-free state, on the other hand, without fail resulted in a rapid loss of virus activity within a few hours to a few days, even when the same agent may have remained virulent in the lyophilized, deep frozen or refrigerated states for several weeks to several years. This situation is well summarized by Topley and Wilson (7) who state, "Most viruses appear to be very resistant to cold. Frozen and dried, they may live for many months. Survival in saline or Ringer's solution varies considerably. In the ice box many viruses will survive a long time, but most of them perish rapidly if kept at room temperature or 37° C." Similar statements were found in many isolated reports dealing with special problems in virology where it was necessary for the investigator to find some suitable method for the storage of his viral agent when he wished to preserve it for study from day to day. There can be no doubt that the virus of homologous serum jaundice withstands lyophilization, deep freezing and refrigeration for prolonged periods of time since all of the reports of homologous serum jaundice relating to plasma transfusion resulted from plasma stored under one of these three conditions. Since these are the best methods for the preservation of any viral agent, it is apparent that these methods of plasma storage contribute to the preservation of the virus and to the perpetuation of the disease. It is equally obvious that if these methods for plasma storage are continued, some method must be found to render plasma free of viral activity before the product is stored under any one of these three conditions.

Is the storage of plasma at room temperature as we have employed it adequate to destroy the virus of homologous serum jaundice? Our data do not permit a conclusive answer to this problem although they weigh heavily on the positive side. In this connection, the following information is available: 13,490 units of liquid room-stored plasma have been administered to 960

TABLE 2
Survival Characteristics of Thirty-Three Viruses under Various Conditions

Note that in every instance where data are available lyophilizing, deep freezing or refrigerating favors prolonged virus survival, whereas room temperature storage in a liquid cell-free media is uniformly detrimental.

Virus	To 0° Cold	0°-37° Room Range	37° Up Heat	Freezing-Drying	Physical Agents	Phenol	Glycerol	pH Change	Other Chemical Agents
Rabies	T* > 1 yr. at < 0°	> 24 hr. at 4°	< 1 hr. at 56°	several yrs.	UVL destroys	Very resistant	Weeks at room temp. several months at refriger.		Formalin, HgCl ₂ Acid & bases destroy
Poliomyelitis	T > 12 mos.		T 3' at 50°		< 3' to oxidants & UVL	T > 10 days in 1%		pH 4-10 stable	KMnO ₄ & HgCl ₂ several hrs. survival > 30' 1:1,000,000 chlorine
Infective Hepatitis			> 30' at 56°						
Serum Hepatitis			< 10 hrs. at 60° in albumin	Preserved					
Common Cold	- days at °								
Atypical Pneumonia	> 5 mos. at -76°	< few hrs. at room temp.	< 5' at 56°		UVL destroys	< 1 wk. in 0.5%		pH 6.5 - 7.8 stable	Formaldehyde destroys
Influenza		> 1 mo. 5° if buffered							
Smallpox	Stable at -70°	> 1 yr. at room temp. if dried	< 30' at 55°	Stable	Stable to Drying		50% - stable		
Vaccinia	Stable at -20°			Stable	Destroyed by UVL, X-ray & light		Stable in gly. if refrigerated		
Psittacosis	Stable at -10°								Destroyed by dyes. Inhibited by penicillin & amino acids & antiseptics
	> 2 yr. at -70°	several wks. at 4°	10' at 60°			< 36 hrs. in 0.5%	10-20 days in buffered 50% glycine at 4°		< 36 hrs. in 0.1% formalin
Lymphogranuloma venereum	> 1 yr. at -30° - -70°	2-4 days at 31°	< 10' at 56°		< 30' to UVL	24-48 hr. in 0.5%	< 7-14 days in 50%		< 30' in 10% ether
Trachoma	< 1 week at refriger.		> 15' at 45°		Killed by drying, freezing, thawing		1 wk. in 50%		formalin T < 30' in 10% ether
Inclusion conjunctivitis	< several days at refriger.				Killed rapidly by drying		< Several days in 50%		Sulfonamides cure in vivo - unaffected in vitro
Measles	< 4 wks. at -72°	> 34 hrs. at room temp.		> 15 wks.					> 40' in 10% ether
Herpes simplex	4 wks. at -35° Several days at 0° > 1 yr. at -70°								
Epidemic keratoconjunctivitis	Stable at -70°								Inactivated by methylene and light
Mumps	> 10 mos. at -70°	> 2 mos. at 4° < 4 days at room temp.	< 20' at 55-60°		Inactivated by UVL		> 1 yr. in 50% at 8°		
							Stable in 50%		Inactivated by 0.1% formalin

patients. Each patient receiving pooled plasma was on the average exposed to 48 donors. None of these patients were known to have developed jaundice attributed to the plasma given. During the same period 28,549 units of blood were administered to 7,893 patients, 26 of whom came down with the classical picture of the disease. Seventy-two per cent of the patients receiving plasma were observed in the clinic from four to six months or longer. Sixty-six per cent of the patients receiving blood were observed for similar periods.

Of the plasma group, twenty-two patients received large volumes of plasma representing donor populations of 200 to 726. This group of patients were under a clinical study relating to the nutritive value of plasma and all were followed for six months or longer. None developed detectable evidence of jaundice. The patient who received 726 donors suffered from hypoglobulinemia and had little or no detectable gamma globulin. This patient should have been more susceptible than usual to the disease. On the basis of the carrier rate for homologous serum jaundice presumed to exist in this country, at least eleven of these twenty-two patients should have come down with the disease. While these patients serve as strong supporting evidence that the virus of homologous serum jaundice is non-pathogenic after prolonged storage in a liquid cell-free state at room temperature, they, too are not conclusive. The final answer to the room temperature storage problem can only be established when plasma known to contain the virus is divided into two lots, one of which is stored at room temperature for three months or longer and the other of which is stored for similar lengths of time but in the lyophilized or frozen state, and then samples of these two types of plasmas administered to human volunteers. An experimental procedure of this type, however should be conducted by the appropriate authorities who have conducted similar experiments in the past.

Since all efforts thus far to render pooled

plasma free of the active virus of homologous serum jaundice have failed, should we continue the procedures of lyophilization, deep freezing or refrigerating plasma? The assembled evidence clearly condemns these procedures as favorable for the transmission of the disease, and soundly establishes the fact that under these conditions of storage the virus does survive. On the other hand, our own data lack the absolute proof that is necessary to suggest that the room temperature storage of plasma method should be substituted for the currently employed procedures. Moreover, it is but a matter of time until some method will be found to kill the virus of homologous serum jaundice before plasma is stored. When such a procedure is established, we can resume the storage of plasma in the lyophilized, deep frozen or refrigerated states without fear of the preservation of homologous serum jaundice.

The method of the storage of plasma in a liquid state at room temperature is not applicable to whole blood, as blood will hemolyze within a day or two and is no longer suitable for transfusion purposes. In the second place, the only method for the cultivation of viruses is their incubation in warm temperatures in the presence of living cells. Thus on two counts room temperature storage is unsuitable for whole blood.

SUMMARY

1. The procedures of lyophilizing (drying), deep freezing or refrigerating plasma are favorable to the prolonged preservation of viruses, including the virus of homologous serum jaundice. Since all methods (including ultraviolet irradiation) to kill the virus in plasma have failed, these procedures of plasma storage should be continued only with full knowledge that they also preserve the virus if it is present.

2. Viruses do not withstand prolonged room temperature storage in a liquid cell-free state. Experience with liquid plasma stored at room temperature for three months or longer suggests

that this procedure will reduce if not abolish the incidence of homologous serum jaundice from plasma.

3. The virus of homologous serum jaundice appears to survive from one to three years in dried plasma stored at room temperature.

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DR. TRIMBLE: Thank you very much indeed, sir, for this most comprehensive and most timely, most authoritative talk on this very important disease. I hope that during the comments later, that perhaps Dr. Allen will tell us something he knows about the problem that exists now in the Armed Forces in Korea. For example, they are having so much trouble with these reactions such as homologous serum jaundice following the use of pooled plasma. However, I'll delay the discussion of this paper until we hear from Dr. Conley.

DR. I. RIDGEWAY TRIMBLE: Our own resident of the City of Baltimore, Dr. C. Lockard Conley, is named after the great friend of his family, Dr. Carroll Lockard. Many of you knew that beloved physician who died a year and a half ago. Dr. Conley is now Associate Professor of Medicine at Johns Hopkins University, he is in charge of hematological diseases, particularly hemorrhagic disorders. He graduated in Medicine from the Physicians and Surgeons College in New York, then interned at the Presbyterian Hospital there, and later went into the Army Medical Corps and worked there in aviation physiology before coming to Hopkins. So we are deeply proud of Dr. Conley and I look forward to hearing him on this program.

UNTOWARD REACTIONS FROM BLOOD TRANSFUSIONS

C. LOCKARD CONLEY, M.D.

Early attempts to transfuse blood were frustrated by the unpredictable occurrence of serious or fatal reactions. The discovery of the blood groups by Landsteiner at the turn of the century for the first time provided an explanation for these unfortunate reactions. His observations established a sound basis for the safe administration of blood. The first World War gave a strong impetus to the use of transfusions, and at that time stored blood was first used. However, it was the development of the blood bank in the late 1930's which made possible the present day large scale use of blood transfusions.

With the development of modern techniques for handling blood and testing for compatibility, serious immediate reactions to transfusions are rare. For this reason, transfusions have become

so commonplace that they are often given on relatively slight indication. In the past few years, however, we have come to learn that blood is not always so innocuous. We recognize now that serious or troublesome late complications not infrequently follow the administration of blood. The risks of transfusion are relatively slight in comparison to its benefits in many situations. However, the risks are sufficiently great to make transfusion inadvisable in conditions in which no real need for administration of blood exists.

Some of the most serious complications of transfusion are ascribable to human error. The methods currently available for typing and cross-matching blood are so precise that, theoretically, incompatible blood should never be administered. Although most hospitals have set up elabo-

rate precautionary routines to prevent such accidents, an occasional patient does receive the wrong bottle of blood. The conscious patient most often will display a prompt reaction to the infusion of relatively small amounts of incompatible blood, and usually the transfusion can be discontinued before serious damage has been done. On the other hand, a patient whose activity is depressed, as by general anesthesia, may receive large amounts of incompatible blood before an untoward reaction is observed. Shaking chill, so prominent a feature of the reaction in an alert patient, does not occur in the anesthetized individual. A drop in blood pressure may provide the first evidence of an incompatible transfusion reaction. In a patient undergoing surgery, the significance of this shock-like state may easily be misinterpreted and the transfusion continued. In some patients the initial shock is very profound, and requires treatment with transfusion of compatible blood. An occasional patient will die during the initial period of shock, but most survive this phase.

Patients receiving a large amount of incompatible blood may develop a remarkable hemorrhagic tendency. The sudden occurrence of diffuse abnormal bleeding may be the first manifestation of an incompatible transfusion. In a recent report by Muirhead (1), 9 of 37 patients who received incompatible blood displayed this hemorrhagic disorder. Bleeding may be very severe and virtually impossible to control. Until recently hemostatic dysfunction had not been elucidated. Last year we had an opportunity to study a case of this type. Dr. Grant Ward was performing a breast operation on a middle-aged woman. During the course of the operation a blood transfusion was started. Shortly thereafter, blood began to ooze from the wound. Diffuse bleeding became serious and uncontrollable. The patient's blood pressure dropped to very low levels, and the operation had to be terminated. Several additional transfusions were given in rapid succession in an effort to combat the hemorrhage and shock. Dr. Ward noted the

relationship of the abnormal bleeding to the administration of the first transfusion, and requested that the cross-matching be rechecked. It was discovered that the blood used in the first transfusion was incompatible. Study of the patient's blood showed the presence of serious coagulation defects. There was a profound reduction of the prothrombin concentration of the blood to a value less than 20% of normal. Plasma fibrinogen was reduced to 21 mgm. per 100 ml., about one-tenth the normal value. The platelets had decreased to less than 100,000 per cmm. There was no heparin or other anticoagulant in the patient's blood. This observation was of special interest because it has been suggested by others that the appearance of heparin in the blood might be the cause of this hemorrhagic disorder. The coagulation defects in this patient were very similar to those which we have produced experimentally by the intravenous infusion of thromboplastin in dogs. Furthermore, the infusion of hemolyzed blood into dogs may give rise to a similar hemorrhagic state (2), a phenomenon which we have been studying. It is apparent from the nature of the blood abnormalities that the treatment of this condition consists of the transfusion of large amounts of compatible blood. Following the administration of several transfusions to the patient studied, there was a progressive rise in prothrombin and fibrinogen values over a period of hours, and abnormal bleeding stopped. Although the prothrombin and fibrinogen concentrations promptly returned to normal, thrombocytopenia persisted for several days.

The administration of even small amounts of incompatible blood leads to prompt intravascular hemolysis of the injected cells. The appearance of hemoglobin in the plasma is good evidence for this occurrence. When a patient develops a chill, febrile response or other reaction suggesting the possibility of an incompatible transfusion, a sample of the patient's blood should be centrifuged to determine if the supernatant plasma is hemolyzed. This simple procedure aids

in the differentiation of incompatible blood reaction from more benign responses which occur fairly frequently, and in which hemolysis of red cells does not occur. The appearance of large amounts of hemoglobin in the plasma is followed by excretion of the pigment in the urine. The urine following an incompatible transfusion is sometimes red in color, but most often is dark brown or almost black because of the presence of altered hemoglobin. It is important to remember that the hemoglobin has been released from the red cells and is in solution in the urine. It can be readily identified by the use of the benzidine or guaiac test, but the urinary sediment may be normal. The appearance of dark urine immediately following a blood transfusion is very suggestive of a hemolytic reaction. In some patients, the reaction is limited to the hemoglobinuria and prompt recovery occurs without further complication.

In many instances, however, severe impairment of renal function occurs, and production of urine may cease entirely. The renal shutdown may persist for several days, and often continues for 2 weeks or more. During this period when the kidneys are not functioning, there is the development of progressive nitrogen retention and the usual other evidences of uremia. The phase of renal shutdown is potentially very serious, and the patient may die of renal insufficiency. There is a strong temptation on the part of the physician to resort to heroic efforts to restore renal function. Many of these patients have received intravenous infusion of hypo- or hypertonic solution in an effort to "open" the kidneys. The use of such solutions has unquestionably hastened the death of many of these patients. With the kidneys not functioning, the normal compensatory mechanisms by which the osmotic and electrolyte status of the blood is maintained is lost. It is, therefore, important to avoid the administration of fluid or electrolytes, either orally or parenterally, if these substances might further distort the chemical pattern of the blood. The lower nephron nephrosis which follows in-

compatible transfusion is most often a self-limited condition. The main object of therapy, therefore, is to keep the patient alive until kidney function is restored. A number of very dramatic procedures have been used in an effort to substitute for renal excretion during this period of anuria. The use of the artificial kidney is one approach. Peritoneal lavage has been employed to remove accumulated nitrogenous and other end products of metabolism. Exchange transfusions have been used to accomplish the same result. In the average case, however, it seems that these elaborate procedures are unnecessary. A conservative method of treatment suggested by Bull and his associates (3) in 1949 has now had a fairly extensive trial, and has given results which appear to be better than those obtained with most other methods. The basis of the treatment is the administration only of sufficient water to make up for the daily extra-renal loss, plus calories in the form of fat and carbohydrate. No electrolytes are administered, since none are being lost, and protein is avoided in order to avoid accumulation of the end products of protein metabolism. In practice, a stomach or duodenal tube is introduced. The patient receives by steady drip through the tube the following mixture:

Glucose	400 gm.
Peanut oil	100 gm.
Acacia q. s.	to emulsify
Water	to 1 liter

This formula is given each day. If the patient vomits, the vomitus is strained and added to the tube feeding mixture in order to prevent loss of electrolytes. In this way, serious disturbance of water and electrolytes can be prevented during the period of anuria. No parenteral fluid is given. When urine flow begins, there is usually production of large quantities of urine of low specific gravity. It is then necessary to add sufficient water and electrolytes to make up for the urinary loss. Although the initial water output may be very large, totalling several liters per

day, impairment of nitrogen excretion persists, so that protein intake should remain low until the NPN has fallen. With this regimen, patients may be maintained in a fair state of general health. A high percentage of patients with complete anuria due to incompatible blood have recovered when treated by this method, even though no urine was produced for two weeks or more.

The patient previously described, who developed a hemorrhagic state following the administration of incompatible blood, subsequently developed complete anuria. She produced virtually no urine for two weeks. She was treated by the tube feeding method under the supervision of Dr. John Eager Howard. On this regimen the NPN rose to a maximum of 242 mgm. per 100 ml. on the 18th day. There was a rise in serum potassium and decline of the CO_2 and chloride, but electrolyte alterations were surprisingly slight. The period of anuria was followed by increasing urinary output until there was pronounced polyuria. During this phase, the NPN gradually decreased. Anemia developed during the episode of nitrogen retention, and was treated by transfusion. The patient has subsequently shown good recovery, although there was prolonged evidence of impairment of renal function. Fortunately, our experience with transfusion reactions of this type is extremely limited. However, we are much impressed by the advantages of the method of therapy which I have described.

Some transfusion reactions are so mild that it may not be recognized that incompatible blood has been given. This is particularly likely to be the case when there is intragroup incompatibility. Thus, a patient who has Rh antibodies in his blood may show only a mild febrile reaction if blood of incompatible Rh type is given. However, the administration of the incompatible blood may cause the patient's antibody titer to rise, so that a subsequent transfusion of the same blood may lead to a more serious reaction. Rh incompatibility is less easy

to detect than ABO incompatibility, since it is usually not evident in the routine cross-matching. An example will illustrate the difficulties which may occur. One of our patients required repeated transfusions. The patient had been found to be Rh negative. However, when given transfusions of Rh negative blood she often had a severe chill and febrile response. The cross-matchings showed no agglutination, and it was not immediately recognized that the blood administered was incompatible. More careful study provided the explanation for the reactions. The patient had developed in her plasma an antibody against Rh'. Rh' is one of the minor Rh factors which is not routinely tested. A donor whose blood is said to be Rh negative (i.e. Rh^o negative) may actually be Rh' positive. Such blood, when administered to the patient in question, caused the untoward reaction. Incompatibilities of this type are readily detected if the cross-matching is done with the red cells suspended in serum or in albumin solution instead of the usual saline suspension. Some authorities recommend that cross-matchings routinely be performed in serum in order that incompatibilities due to so-called incomplete antibodies may be detected.

When febrile reactions occur, it is important to exclude the possibility of incompatibility. However, most febrile responses to transfusion cannot be accounted for on this basis. Usually these reactions have no serious consequences. An extremely serious situation has been described in which the reaction is caused by bacterial contamination of the blood administered. If the apparatus in which the blood is collected is not properly sterilized, non-pathogenic organisms may proliferate in the blood. When this blood is administered, a pronounced reaction occurs, with marked chill and fever, and profound shock. The response resembles an incompatible transfusion reaction, but examination of the plasma and urine shows no evidence of hemolysis. Death may occur in a few hours. Accidents of this type are apparently very rare, but the possi-

bility of their occurrence indicates the importance of carefully maintaining the sterility of stored blood.

A curious incident of transfusion which has interested Dr. Sherman Mellinkoff and myself is the occasional occurrence of curious infiltrations in the lungs. We have seen several patients who have developed fever following transfusion and have been found to have rales in the lungs. X-rays taken immediately after the transfusion have shown areas of opacity which then clear very rapidly. The picture is not that of the usual pulmonary edema, and Dr. David Gould, roentgenologist, feels that the x-ray changes might be best explained on the basis of an allergic reaction involving the lungs.

True pulmonary edema has often been induced by the administration of blood to a patient in incipient heart failure. In transfusing patients with lessened myocardial reserve, it is wise to keep the rate of infusion slow. There is a great advantage in decanting the plasma from the bottle of blood and injecting only the red cells. In this way the volume of fluid administered is kept at a minimum, and pulmonary edema is not so likely to occur.

In certain other instances it is advisable to remove the plasma and to transfuse only the red cells. This may be true in any situation in which it is desired to correct anemia without enlarging the plasma volume. In some rare disorders, patients react unfavorably to the infusion of plasma, whereas washed red cells may be well tolerated.

Minor allergic reactions to transfusion are common. Urticaria is the most frequent manifestation. Bronchospasm and asthmatic breathing are much less often encountered. These allergic symptoms are ordinarily easily controlled by the use of antihistaminics, adrenalin and related drugs. Hypersensitive individuals may have more serious reactions. One of our patients with a Henoch-Schonlein type of purpura developed an alarming hemorrhagic angioneurotic

edema during the administration of a blood transfusion.

An important danger of transfusions which has been recognized only in recent years is the possibility of sensitizing individuals to the Rh factor. If Rh positive blood is administered to an Rh negative subject, antibodies against the Rh factor may develop. If the patient concerned happens to be a female who subsequently bears an Rh positive fetus, there is the real possibility of the occurrence of hemolytic disease of the newborn. The almost universal performance of routine Rh typing should make this unfortunate complication an infrequent occurrence in the future.

One important late complication of the administration of multiple transfusions is the development of hemachromatosis. This is a condition not likely to be encountered by surgeons, but it is seen occasionally in patients who receive many transfusions for anemia not caused by blood loss. A pint of blood contains about 250 milligrams of iron. There is no mechanism of excretion of iron from the body once it has been absorbed, and iron can be lost only by blood loss. The iron administered in the form of blood transfusion is therefore permanently retained in the body of an individual who is not bleeding. When large numbers of transfusions are given, relatively enormous amounts of iron are deposited, particularly in the liver, spleen, and glandular structures. Typical pigment cirrhosis of the liver may develop, and in addition, the involvement of the pancreas may give rise to diabetes. The clinical as well as the anatomical features are essentially identical with those seen in "idiopathic" hemachromatosis. A number of our patients with prolonged refractory or hemolytic anemia have developed this syndrome.

At the present time, by far the most common serious complication of transfusion is the transmission of disease. A variety of infectious agents can be transmitted by this means. Proper screening of donors largely eliminates the possibility of infecting the recipient with syphilis, malaria, and other easily recognizable diseases. In a rare

instance, certain other serious infections may inadvertently be transmitted. We have seen one patient develop fatal typhus fever following transfusion of blood from a donor who had recovered from the disease in another country many months before.

The most grave danger of transfusion today is the possibility of transmission of hepatitis. The incidence of homologous serum jaundice is distressingly high. We encounter it so frequently that when we see a jaundiced patient, one of our first questions is "when was he transfused." A study carried out by Drs. Ratnoff and Mirick (4) at the Johns Hopkins Hospital indicated that one of each 330 patients transfused in that hospital during the period of study returned with hepatitis after transfusion. Undoubtedly many others developed jaundice but were not readmitted. One patient is known to have died of hepatitis among each 1400 patients transfused.

Of 40 cases of homologous serum jaundice following transfusion, there were 11 deaths in this series. It is apparent that until the problem of homologous serum jaundice can be satisfactorily overcome, physicians should be conservative in their use of transfusions.

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DR. TRIMBLE: I'm sure that the section on Surgery is equally grateful to you Dr. Conley for your splendid paper. We wish to thank you for it.

DISCUSSION

DR. TRIMBLE: These two papers are now open to discussion. Does anybody have any questions?

DR. PETERS: The hour is growing late but I do wish to express my appreciation of the talk of Dr. Allen. There is the stimulating idea of something new there. I might in a moment have a question to ask Dr. Conley. In the event of hemolytic transfusion reactions there may well come a time when suppression of urine occurs and at that stage there is apt to develop high hysteria—not only of the relatives but even of the doctors and many dramatic therapies have been advocated in the past. I can remember quite a number of years back that such a situation occurred in the first Rh case—and I must add that from our clinic at the Mercy Hospital, the first Rh cases did emanate. In one case there was anuria for about eight or nine days and after the use of a rather simple procedure, splanchnic block, the patient voided large quantities and went on to make a satisfactory recovery. I later, then, wrote an article on splanchnic block.

Since that time, as Dr. Conley has mentioned, the more conservative therapy of Bull and others has come into vogue very definitely.

I think I remember that in 1948 or 1949, Dr. Conley wrote an article in the *American Journal of Clinical Pathology* and he was possibly among the first advocating exchange transfusions in an adult for hemolytic transfusion reactions and with presumably very good results. I do know that in more recent years,—with a better concept of the course of the condition and the results of proper conservative treatment, I have at times hung my head over the earlier advocacy of splanchnic block and felt it may well have been pretty much poppycock. However, not many months ago I received an autographed copy of a reprint from Australia. This man, after his introductory paragraph, said that "Peters was the first to bring forth in the English language the use of splanchnic block" and then presented a case ascribing recovery to the method. I presume the only conclusion here is that "the evil

we do lives on after us." I might now ask Dr. Conley whether many have reported their experience and success to him in using replacement transfusions.

The only other comment I can make is that Dr. Allen, in very correctly mentioning the "father of all blood groups" Landsteiner who first described three main groups in 1901, implied that he also described the Rh factor before his death. This is not strictly accurate and again brings my memory back to the initial Rh business. Dr. Landsteiner, working with Weiner, did define a new agglutinin from work done on animals—from the reaction of Rhesus monkey blood with guinea pigs or rabbits but that work lay unnamed in the laboratory of Dr. Alexander Weiner. When I took our clinical cases with an irregular agglutinin to Dr. Weiner he found it was identical to the agglutinin found by animal work and it was then that the first article on "Rh" was written,—my part being largely the humble one of defining the clinical aspect of the cases. I still remember going to New York just before publication of the article and still get a slight thrill at the tiny bit of reflected glory in that Dr. Weiner called me to ask my opinion as to whether we had not better call the agglutinin "Rh" rather than agglutinin "Y" as was initially intended. I can still remember that, with my comparative ignorance and his profound knowledge of blood group serology, I was humbly delighted for him to call it anything he desired.

DR. TRIMBLE: Dr. Ravitch?

DR. RAVITCH: These were splendid papers and it is hard to realize how few years ago we were pleading for the use of more and more blood for more and more people on smaller and smaller indications. Now it has gotten to the point where it almost seems unsafe to transfuse anybody at all. Of course that isn't so, we are using something like eight thousand bottles of blood a year in our hospital but only about six or seven hundred half pints of plasma a year, so we are using very much less plasma now than we were using some time back. As far as the danger of

homologous serum jaundice is concerned—and it is now the only disease we worry about—syphilis has disappeared partly because everybody sick enough to get blood is sick enough to get so much penicillin that no self-respecting treponeme would survive in his bloodstream and partly because the treponema dies in the icebox during the period of storage, and malaria just hasn't turned out to be the problem that we thought it would after the war. But homologous serum jaundice is still a very great problem and perhaps the biggest problem is the fact that it survives both in blood and in plasma. We use so much more blood than we do plasma and almost none of the methods which are applicable or may be applicable to the destruction of the infectious agent in plasma are applicable to its destruction in blood.

We have had a good many of the cases which Dr. Conley mentioned in our series originating from blood, sometimes from just a single blood transfusion. I wonder if Dr. Allen knows what the experience of the Armed Forces in the early part of the war and just before the war was with liquid plasma stored at room temperature. Commander Newhouser and the then Captain Kendrick, I believe, prepared liquid plasma for the use of the Armed Forces in the States. They were sending lyophilized plasma overseas; the facilities were limited and all the plasma used in this country at that time in the Armed Forces was liquid plasma. Now, it may be the demand was so great and the supply so small that it wasn't stored very long. Dr. Conley's remarks were fascinating to me. I'd only like to ask him whether he could comment on the recently suggested use—at least Dr. Champlyons, Professor of Surgery at Birmingham, Alabama told me of it—of salt-free human albumin as a specific for the hemorrhagic diathesis followed transfusion of mismatched blood.

DR. TRIMBLE: If there are no other comments or questions, I'll ask the speakers to close. First, Dr. Allen.

DR. ALLEN: Colonel Kendrick informed me

that at the beginning of World War II a large volume of plasma was stored at room temperature and administered, but neither he nor Capt. Newhouser had information regarding whether this product produced homologous serum jaundice.

When we originally became aware of the possibility that the virus of homologous serum jaundice died out after prolonged storage in a liquid state at room temperature, we collected all the data we had available at that time and held it for nearly two years before submitting it for publication. Our delay in publication was occasioned by the desire to obtain the opinions of a number of virologists in this country as to the validity of our thesis. In addition, the original data were circulated among a number of men who had worked for many years in the field of homologous serum jaundice. For their wise counsel I am deeply indebted. One of the interesting outgrowths of this correspondence came from Doctor W. D. A. Maycock of the British Ministry of Health, to whom I wrote to obtain information regarding the method of storage of several types of human immune sera distributed by the British Ministry of Health during the late 1930's. From these sera came several reports of homologous serum jaundice and it was necessary to establish how these particular products had been stored. I told him of our thesis and why I was interested in obtaining the information requested. He reported that these sera had been refrigerated. In the course of his letter he stated that the Australians had stored pooled plasma at room temperature and had encountered a 2.7 per cent incidence of homologous serum jaundice. At Doctor Maycock's suggestion, I contacted Doctor R. J. Walsh at Sydney who was in charge of the Red Cross Blood Transfusion Service which at that time supplied all plasma for Australia. Doctor Walsh verified the incidence of homologous serum jaundice but informed me that their product at the time of his writing, July 7, 1950, had been frozen and that it was shipped throughout the Australian continent in

the frozen state. There was further opportunity to verify Doctor Walsh's statements by Doctor K. W. Starr also of Sydney who visited our hospital a few days after I had heard from Doctor Walsh. In addition, Doctor Carl Moore of Washington University in Saint Louis informed me last December that they had administered some 4,000 units of liquid plasma stored at room temperature and were unaware of the development of homologous serum jaundice in their patients. Doctor J. J. Griffiths of the Blood Bank of Dade County, Inc. states that in over 7,000 units of plasma given after storage at room temperature for prolonged periods of time in a liquid state, they have received no reports of the development of homologous serum jaundice.

Again I wish to emphasize that while these data, as well as the theoretical considerations, weigh heavily in favor of the virus "dying out" in liquid plasma stored at room temperature, they do not produce the factual proof necessary to make the evidence conclusive. On the other hand, evidence is conclusive that the virus of homologous serum jaundice withstands readily lyophilizing, deep freezing or refrigerating, and that these methods of storage probably perpetuate transmission of the disease in such plasma.

DR. TRIMBLE: Thank you Dr. Allen. Now Dr. Conley?

DR. CONLEY: It is a great pleasure to be able to disclaim any responsibility at all for either having performed exchange transfusion or having written about it in the treatment of renal shutdown. I had nothing to do with that. The only exchange transfusions that I have ever seen used in adults were given in the treatment of acute leukemia, and I was much impressed by the difficulties and problems associated with the carrying out of the procedure and think the more conservative method of therapy would certainly be more preferable.

In regard to Dr. Ravich's question with reference to the use of serum albumin in the treatment of hemorrhagic disorder associated with incompatible transfusion reaction, I can only say

that if the case we studied is representative of the group, you would certainly not expect that albumin would be helpful since the fraction does not contain either prothrombin, fibrinogen or platelets. Unfortunately we have not had an opportunity to study any other similar cases. We would be delighted to study a group if Dr. Ravich would arrange to make them available to us.

DR. TRIMBLE: Thank you, Dr. Conley. Now Dr. McLanahan will you take over?

DR. McLANAHAN: It is my pleasure to conclude this meeting and to thank Dr. Trimble and Dr. Kimberly for arranging this program, and to thank particularly again our two essayists of the evening.

We are adjourned.

LARGE HEMORRHAGES FROM THE BOWEL OF OBSCURE ORIGIN

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The problem considered in this paper may perhaps best be approached by several negations. It does not concern the frequent passage of relatively small quantities of fresh blood, such as occurs in a number of lesions of the anal canal and lower rectum. It does not deal with cases chiefly characterized by the associated vomiting of blood, nor does it consider large hemorrhages from the bowel of a fairly obvious nature. On the positive side, the following may be presented as a fairly characteristic picture of the condition under discussion. A patient apparently quite well, and certainly not known to be suffering from any alimentary tract disorder, is suddenly seized with an urgent desire to defecate. Instead of stool, however, there is passed a large quantity of blood. This may vary in color from bright red to tarry. Accompanying this movement there is often faintness, dizziness, and sometimes actual syncope. With this there may be nausea or vomiting. There is usually no abdominal pain, although some peristaltic cramps may precede and accompany the evacuations. There are often one or two less copious passages of blood after the first one. The patient is left weak, pale, and shaky with a rapidly developed

secondary anemia and a rapid pulse and low blood pressure. This then is the general clinical picture. Certain questions at once arise. How common is such an occurrence? How serious is it? How should it be dealt with? The purpose of this paper is to attempt to answer some, at least, of these questions.

Such cases are fortunately not frequent, and yet they are by no means rare. Most surgeons, and many general practitioners can recall at least one or two instances of this sort, and many will have had a more extensive experience. It so happened that the writer encountered nine such cases in one year, and was stimulated by this rather unusual coincidence to review his whole record and the records of the hospitals in which he works over a period of some ten years. The material thus accumulated has been published in a previous paper. With certain additions it provides the data for this article. The number of cases herewith reported is 79. These cases may be divided into three major groups, which will be considered more in detail later.

The question of how serious these cases may be will of course be made evident by the further discussion, but at this point it may be said that

most of them recover under proper care, although a few undoubtedly succumb in spite of any treatment. It should be stated here that a fair number of such patients give a history of one or more similar attacks previously recovered from.

The handling of such cases involves two principal efforts. The treatment of the immediate condition and the discovery of the cause of the bleeding. The former objective is of course the more urgent. The writer has developed the following method of *immediate treatment*, which is not advanced dogmatically but has proved satisfactory in practice. Surgical attack is not seriously considered in the early stages of the illness. The poor condition of the patient and the unknown location and nature of the lesion are sufficient reasons for this decision. Such patients should not be subjected to an exploratory celiotomy that would very possibly be fruitless. The patient should be put to bed at once, with the feet elevated. Morphine hypodermically is probably useful. If the hemoglobin shows a reduction to or below 60 per cent, and if the systolic blood pressure falls below 90, a transfusion of whole blood is given. In most instances this may not be absolutely necessary, but it is the most effective and rapid restorative of the general condition. Giving the blood slowly, and not in larger quantities than 500 cc., has not been followed by harmful effects, except in one instance where a sharp chill and reaction occurred in spite of a very good match. One of the cases herewith recorded is reported to have died after a transfusion given elsewhere for a subsequent attack of bleeding, but whether there was any causal relation between the transfusion and the death is not known. The often expressed fear that transfusion may cause renewed bleeding has not been realized in practice. All food by mouth should be stopped, and only small amounts of water allowed. Intravenous fluids sufficient to keep water balance are administered. The inclusion of plasma in such fluids has been adopted in the past years and is believed

to be helpful. In the great majority of cases the bleeding stops within 48 hours and the patient is rapidly rehabilitated from the early low level of the initial shock. However, such patients often require two to three weeks for complete restoration, and during this time look pale and are weak. Some of them lose as much as ten pounds in weight.

The *diagnostic study* of the case, except for such innocuous procedures as careful history taking, gentle abdominal examination, and rectal palpation, is best postponed until the up-turn in the general condition is well advanced. Then a sigmoidoscopic examination, a barium enema and gastrointestinal roentgenologic study are in order. Blood studies to exclude thrombocytopenia, or other significant abnormalities, are also carried out.

As a result of the diagnostic efforts, the cases may be divided into three groups: In the first, which in my experience is the smallest group, a definite lesion, such as a duodenal ulcer, may be discovered that is adequate to explain the bleeding. In the second group, there may be found certain anomalies, not usually associated with gross hemorrhage, but which may *perhaps* be regarded as responsible for the bleeding. Of these, multiple diverticulosis has occurred several times in this series of cases. The third group, the most interesting and largest, remains completely obscure. The history, the clinical study, and the various special investigations, including roentgenologic examination, reveal nothing of significance. The existence of this considerable group of cases is the conclusive reason against early operation. Operation under such condition is a pure "shot in the dark." Of course in those instances where a lesion of distinctly surgical nature is discovered, the definitive treatment, after restorative measures, is operative removal.

The subsequent history of these patients is interesting. A considerable number of them *do not bleed again*. Others may bleed after long intervals of freedom—in one case in this series the interval was 20 years. Still others may be

subject to recurrent hemorrhages a number of months apart. As these recurrent cases may also belong in the group with no diagnosed lesion, the decision as to further treatment becomes very difficult. Should one sit helplessly by and let the grave hemorrhages continue, or submit the patient to an abdominal exploration that may prove fruitless? For experience has shown that even the most searching explorations may fail to disclose the source of the bleeding. Indeed, autopsy in the rare fatal cases has sometimes been reported as inconclusive in its findings. On the other hand, sometimes an exploration will reveal, and permit the removal of a lesion, that escaped detection in the study of the case. This possibility, and the natural disinclination to a course of merely passive waiting in the hope that nature may effect a cure, will usually lead to the decision to explore the recurrent cases, and to this attitude there can be no serious objection. Exactly when to operate, and after how much provocation in the form of repeated bleeding, must remain a matter of individual judgment.

The lesions that may be suspected or proved to be the cause of the bleeding form a considerable and heterogeneous list. In the collected cases on which this report is based, the following lesions were encountered in the group with proved cause; carcinoma of the stomach, ulcer of the stomach, ulcer of the duodenum, cyst of duodenum, diverticulosis of duodenum, cirrhosis of liver with esophageal varices, or with portal thrombosis, acute gastro-enteritis, and regional ileitis, Meckel's diverticulum, carcinoma of the colon, ruptured vessel in the rectal wall, lymphoid leukemia, myeloid leukemia, hemophilia, familial telangiectasis. These lesions were demonstrated, either at operation, at autopsy, or by unequivocal findings. Other authors have reported, as additional proved causes, intestinal polypi and other tumors, hemangioma, trauma from ingested bodies, aneurysms, intestinal reduplications, cholecystitis, and the administration of large amounts of aspirin over a long

period, which may produce a hypo-prothrombinemia.

In the group in which conditions were found that might be regarded as possible or probable causes of the bleeding, the following occurred in my collection of cases; dilated blood-vessels found in bowel at operation, history of polypi removed from bowel previously, but none currently demonstrable, hypertensive disease with arteriosclerosis, a number of cases of diverticulosis of the colon, cases with suggestive history of past duodenal ulcer, but no actual proof of it.

The largest group of the reported cases, some 34 in number, were those in which careful study failed to reveal any reason for the bleeding. A number of these cases were explored surgically, some of them more than once, still without throwing any light on the cause of the hemorrhage. The existence of this numerous and puzzling category of clinical cases is the chief reason for calling attention to this baffling problem. It may be of interest to quote the experience of a well-known surgeon related to me personally. Over a period of time he had encountered four of these patients with unexplained large melena. He had explored them all, and found in each case a definite lesion, which was successfully removed, and the patient was cured. He had about decided that the alleged difficulty with such cases was a myth, and that the simple and obvious treatment was to explore, find, and remove the trouble. Then he proceeded to apply this doctrine to the next four cases in his experience, and in each instance the exploratory operation failed completely to reveal any cause for the bleeding. This surgeon now supports the views expressed in this paper.

The cases herewith recorded are too few and too heterogeneous for statistical study, but certain facts are evident. The patients were of all ages, of both sexes, and included both Negroes and whites. The patients with proved causes of bleeding present a variety of lesions, some of which may have been present but undiscovered in some of the unexplained cases. The fairly

numerous cases of diverticulosis of the colon, associated with bleeding, may indicate that hemorrhage into the bowel is a more common occurrence in this condition than is generally believed. Similar bleeding must be recognized as an occasional symptom of the rarer conditions reported among the proved cases. The outstanding observation, however, is the quite considerable group of patients with large melena in whom careful and extensive study failed to reveal any explanation of the source or cause of the hemorrhage.

SUMMARY AND CONCLUSIONS

(1) Report is made of a collection of cases in which the presenting symptom was large hemorrhage, passed per rectum, of obscure origin.

(2) The opinion is expressed that restorative treatment followed by careful study is the proper immediate treatment, and that early operation should not be advised.

(3) These cases may be divided into three groups: (a) Those in which study reveals the definite cause of the bleeding; (b) those in which a lesion is discovered that perhaps accounts for bleeding; and (c) those where exhaustive search fails to show any explanation.

(4) The subsequent history of these patients with no detectable lesion may be free from any further bleeding, or subsequent hemorrhages may occur at varying intervals.

(5) Surgical treatment should be carried out when a lesion of the type amenable to operation is definitely diagnosed after adequate study. Where recurrent bleeding is associated with a lesion that *might* be responsible, and this lesion is suitable for surgical intervention, operation should be advised. In the cases that remain completely unexplained, operation is only a resort of desperation in the face of repeated grave hemorrhages. Such an operation may still fail to discover or relieve the trouble.

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NAME AND ADDRESS OF THE FEDERAL SECURITY AGENCY REGIONAL MEDICAL DIRECTOR

A. M. A., Capitol Clinic, Vol. 3, No. 32, August 12, 1952

Region 3 (District of Columbia, Maryland, North Carolina, Virginia, West Virginia, Puerto Rico, Virgin Islands)—Dr. Albert L. Chapman, Room 2023, Federal Security Building, Washington 25, D. C.

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Doctor, Please Take This Home To Your Wife!

The Woman's Auxiliary cordially invites you to attend its meeting on Wednesday, December 3rd, at 11:00 A. M., at 1211 Cathedral Street, Baltimore.

Mr. John B. Farrell, former Assistant Director of Probation for Baltimore County, will speak on "The Drinking Factor in Juvenile Delinquency". A Buffet Luncheon will follow.

ARTICLES OF INTEREST

MUTINY FOR A BOUNTY*

EDWARD F. LEWISON, M.D.

"True courage consists not in blindly overlooking an injustice, but in recognizing it and remedying it."

The cost of medical reprints has risen to a ridiculous figure. Even the best of these published records of achievement is hardly equal to its prohibitive price. If doctors cannot be entirely spared this exorbitance, they might at least be better protected. The premium placed upon medical men in ordering reprints regardless of their purpose—ambition, vanity or the dissemination of knowledge—is certainly excessive. Perhaps a personal experience but one common, I am sure, to all contributors will more vividly point up the problem.

Some time after the war one of the editors of a flourishing and eminently respectable surgical journal suggested that I prepare a review article concerning one of the currently fashionable diseases of the day in which I was particularly interested. Naively I consented and with a low index of suspicion and a high index of eagerness I wistfully went to work culling the current and not so current literature. Several years and many hapless hours later this collectanea finally appeared in print.

Now although I am by no means a prolific contributor to the medical press, I am sufficiently well aware of the high cost of authorship to know that a profusive pen can pauperize any physician with a flair for foolscap. Thus, in this instance I was content to order a pittance of reprints of this somewhat lengthy 30 page review. Knowing full well that no

person is less competent to judge the number of reprints to be ordered than the author himself, I was more pleased than astonished to find requests coming in by the score long after my supply was exhausted. The limitation of my judgment in these matters is all too apparent in the dusty stacks of past reprints that have remained uncalled for while littering my shelves for years.

However, not long afterward I was shocked to receive a bill for reprints which amounted to almost *one dollar apiece*. These reprints were of standard size, without covers, and included no extra-cost illustrations. As a practicing surgeon without benefit of Federal subsidy or the auspices of departmental patronage this charge, to say the least, appeared to be a fairly flossy figure even for fine rhetoric. Upon inquiring whether this bill might not be in error, I was told by the publisher in tones of honeyed humbug that reprints are sold to physicians at "cost" without profit to the journal. What the publisher neglected to say was what he meant by the word "cost." Does "cost" merely mean the price of paper and printing alone or does it include virtually the whole gamut of a fancy figured business, namely, publishing? It seems scarcely right to charge contributors of free material with a "cost" that more properly belongs to business expense, advertising, distribution, and the like. The subscription price or the profits of selling advertising space should rightly bear this burden alone.

As a surgeon I am naturally quite in the dark about the financial set-up of the publishing business, but there must be "gold-in-them-thar-galleys" or there wouldn't be so many periodicals. Perhaps authors and publishers never see an eye to an eye with regard to reprints because each is looking at the field from opposite ends of the scope. However, certain journals do attempt a reconciliation of the two points of view. To cite but one example, "Cancer" is a bimonthly periodical, priced at a premium but handsomely printed and edited by a star studded editorial staff. Yet, even without the El Dorado of advertising this journal's publishing firm compensates contributors by granting them a gratuity of 100 free reprints.

* EDITOR'S NOTE: Medical and Scientific Journals which must rely wholly on subscriptions to meet publication costs are hardly in a position to supply reprints without cost. CANCER is subsidized by the American Cancer Society, and the subsidy is considered an effective part of the Society's professional education program because it makes possible a wider distribution (due to lower subscription rate) than would be achieved otherwise. The subsidy amounts to \$12,000 per year.

This subsidy makes it possible to supply a limited number of reprints to authors, which again in the interests of better medical communications is held to be a legitimate enterprise of the American Cancer Society.

Thus, the author's contribution is made by giving himself, might not the publisher's bounty be as blessed?

P.S. I regret that due to circumstances with which I am not in accord *no* requests for reprints of "Mutiny For A Bounty" can be honored.

THE CASE OF THE UNITED STATES VERSUS THE HOXSEY CANCER CLINIC

Opinion of the United States Court of Appeals for the Fifth Circuit

The following is quoted from a letter received from Mr. C. W. Crawford, Commissioner of Food and Drugs, Federal Security Agency, Food and Drug Administration, Washington 25, D. C.

You may be interested in the enclosed opinion of the U. S. Court of Appeals for the Fifth Circuit in the case of *U. S. v. Hoxsey Cancer Clinic, a Partnership, and Harry M. Hoxsey, an Individual*. This opinion is the result of an appeal in a vigorously contested case tried in the U. S. District Court at Dallas, Texas. It reverses the judgment of the trial Judge (William H. Atwell, N. Dist. of Texas) and directs that Court to issue an injunction prohibiting the defendants from distributing in interstate commerce brownish-black, and pink, liquids intended for the treatment of cancer in man.

In many parts of the country, people are taking the Hoxsey medicines in the belief that they may be an effective treatment for cancer. Friends and relatives of cancer victims frequently query local physicians concerning this treatment. You may wish to publish information about this case so that physicians will have the facts at

hand concerning these drugs, in the event of such inquiries.

The following important principles are laid down in the Circuit Court opinion, based on testimony by cancer experts.

1. "**** there is only one reliable and accurate means of determining whether what is thought to be cancer is, in truth and fact, actually cancer. This requires a biopsy, a microscopic examination of a piece of tissue removed from the infected and diseased region."
2. "**** the opinion of a layman as to whether he has, or had, cancer, or a like opinion as to whether he has been cured and no longer bears the disease, if, in fact, it ever actually existed, is entitled to little, if any, weight."
3. "**** despite the vast and continuous research which has been conducted into the cause of, and possible cure for, cancer the aggregate of medical experience and qualified experts recognize in the treatment of internal cancer only the methods of surgery, X-ray, radium and some of the radio-active by-products of atomic bomb production."
4. "**** Upon such subjects a Court should not be so blind and deaf as to fail to see, hear and understand the import and effect of such matters of general public knowledge and acceptance, especially where they are established by the overwhelming weight of disinterested testimony****."

The Hoxsey Clinic is located in Dallas, Texas, and ships its drugs to patients in many other States. According to the unanimous opinion of the Court of Appeals, consisting of Judges Russell, Hutcheson, and Rives, "the overwhelming weight of the credible evidence requires a conclusion that the representation that the Hoxsey liquid medicines are efficacious in the cure of cancer is *** false and misleading. The evidence as a whole does not support the finding of the trial Court that 'some it cures, and some it does not cure, and some it relieves somewhat.'"

Under the law the defendants still have the right to petition for review by the U. S. Supreme Court.

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ANNOUNCEMENT FROM THE AMERICAN DIABETES ASSOCIATION

Prize for Paper on Diabetes by Medical Students and Interns

The American Diabetes Association offers a \$250.00 prize to *medical students* and *interns* for a paper on any subject relating to diabetes. The paper can be a report of original studies, a biographical or historical note, a case report with suitable comment, or a review of the literature.

Manuscripts must be submitted on or before April 1, 1953, to the Editorial Offices of DIABETES: The Journal of the American Diabetes Association, 11 West 42nd Street, New York 36, New York. The papers will be reviewed by the Editorial Board, which will take into consideration the value of the material and method of presentation in selecting the best paper.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The following statistics and instructions were submitted by Dr. Leslie E. Daugherty, Medical Director of Civil Defense in Allegany County:

A direct hit from an atomic bomb on Cumberland is possible, but not probable.

The possibility must always confront us and what it would mean should never be dismissed from our future plans.

A direct hit would kill 40,000, the entire population of Cumberland, 80,000 of the surrounding area would need hospitalization, 1600 of which would be known diabetics. Another 1600 have diabetes, that is undiagnosed. Thirty thousand would need outpatient care. Fifty thousand would be evacuees from Baltimore, Pittsburgh and between towns and country-side and uninjured.

This means that the area of direct hit would have a radius of two and a half miles, where everything would be destroyed. Not a bit of evidence of any living thing would be visible, but the parched earth.

Of the injured 80,000, approximately 3200 would have their diabetes worsened and require immediate insulin. Supplies of insulin will and are being stock-piled in this area for immediate use. Sufficient quantities will be available for every diabetic. But, first everyone in this area must know whether he has diabetes or not, because diabetes is made worse by injury or infection and everyone should immediately have his or her urine tested for the presence of sugar and a determination by the family physician as to the probability of diabetes being present.

Do this at once and carry a card on your person at all times, stating that you are a diabetic. You may become unconscious and receive the wrong treatment in an emergency, if it is not known. At the same time, have your blood typed, so that if you need a transfusion it may be given before it is too late.

Prepare to take care of yourself completely, if you are uninjured.

Find out where your Casualty Clearing Station is located and contact it at once if you need help, or want to give aid to others.

MEDICAL CIVIL DEFENSE BOOTH

The County physicians had a Medical Civil Defense booth in the Greater Cumberland Industrial Exposition, at the State Armory, October 16th to 18th, and Dr. Leslie E. Daugherty, Medical Civil Defense Director for Allegany County, announced the following committee was in charge: Dr. Oliver R. Roth, Dr. Clay E. Durrett, Dr. Arthur Jones and Dr. Leo H. Ley.

DR. ROTH TO ASSIST LOCAL DRAFT BOARD*

Dr. Oliver R. Roth, 202 Virginia Avenue, has been named medical advisor to Draft Board 27 in the Union Street County Building.

His appointment to succeed Dr. Earl Edgar Broadrup, 609 Kent Avenue, was announced today by Clerk Co-ordinator P. Emmett Fahey through Col. Henry C. Stanwood, state Selective Service director.

Fahey said Dr. Broadrup, who served the board since September 23, 1948, retired from medical practice August 23rd. Dr. Roth assumed his new duties September 5th.

The clerk co-ordinator also pointed out that draft registrants who get married or become fathers are required to notify their boards of such change in status as soon as possible.

Some young men are still waiting until they get notice for pre-induction physical exams before reporting a change in status. And this is causing a lot of wasted time and lost effort on the part of both Selective Service employees and the registrants themselves.

This is what Selective Service asks young men to do:

As soon as they get married they should write a letter to their draft board, reporting they are married, and enclosing a certified copy of the marriage license.

* From: The Cumberland Evening Times, September 18, 1952.

As soon as a registrant becomes a father he should write a letter to the draft board, reporting the birth of the child and stating whether or not he, the father, is maintaining a proper family relationship with the new baby. A copy of the birth certificate should also be enclosed.

BALTIMORE COUNTY MEDICAL SOCIETY

CHARLES H. WILLIAMS, M.D.

Journal Representative

REPORT OF THE EXECUTIVE COMMITTEE MEETING OF THE BALTIMORE COUNTY MEDICAL SOCIETY

A meeting of your Executive Committee was held Wednesday afternoon, June 4, 1952. The members of the Executive Committee are Dr. Charles H. Williams, Dr. Melvin B. Davis, Dr. Clewell Howell, Dr. David Andrews, Dr. Thomas Wheeler and Dr. Charles F. O'Donnell.

Invited guests and members of the County Medical Society present were Dr. Louis Dalmau, Dr. Wilmer Gallager, Dr. Vernon Langeluttig, Chief of Tuberculosis at Mercy and City Hospitals, Dr. Richard Hanchett, Chairman of the Radiologic Section of the Baltimore City Medical Society, Dr. Leon H. Hetherington, Chief of the Tuberculosis Section of the State Department of Health, Dr. Robert T. Hyde and Dr. William H. F. Warthen of the County Health Department.

The main topic discussed at the Meeting was the overall tuberculosis picture in our county and the general policies of the State Department of Health and the Maryland Tuberculosis Association with regard to tuberculosis.

The following conclusions were reached and are recommended in the form of a motion for adoption, by this Society:

- 1) That the State Department of Health and the Maryland Tuberculosis Association follow the recommendations of last year's Committee on Tuberculosis. These recommendations have been passed by the Society and are merely a re-statement of our policy.
- 2) The physicians of the County be informed by letter that in the future no physical examinations will be done in chest clinics except on request of a physician, and these requests should be limited to those to whom referral to a private chest specialist would work a financial hardship or for those to whom referral to hospital chest clinics are not desired.
- 3) Gastric washings and sputum collected only on physician's request with the same rules as apply in Point No. 2.
- 4) That the statement of the "State Department of Health policy set forth in September, 1951," with regard to free x-rays for employment be clarified to read free x-rays for those needing chest x-rays for employment by State, County or local Government agencies, not for private employment and in the future any private employers using State Department of Health x-rays or Maryland Tuberculosis Association x-rays for employment be so advised.
- 5) All x-ray reports from State Department of Health and Maryland Tuberculosis Association shall be mailed directly to the patient's private physician and it be the private physician's responsibility to carry on from that point.
- 6) In the future, the clinicians at the various chest clinics and x-ray only clinics will confine their activities to reading the x-rays and only examining chests on specific request of the private physician.
- 7) That the Radiologic Section of the Baltimore City Medical Society and all Roentgenologists throughout the counties be requested to discuss the advisability of having a special form which, when signed by a private physician, would entitle a patient to a routine chest x-ray for a fee of \$5.00.
- 8) That this Committee report, after approval of the County Society, shall be sent to the Secretary of the Medical and Chirurgical Faculty of Maryland, the Secretary of each county Medical Society, the Maryland Tuberculosis Association, the Baltimore County Public Health Association, the State Department of Health Director and the Chairman of the Committee to Advise the Health Department of the Medical and Chirurgical Faculty of Maryland. Also, that this report be sent to the *Maryland State Medical Journal* for publication.

HISTORY OF BALTIMORE COUNTY MEDICAL ASSOCIATION (AUTOBIOGRAPHY)

GEORGE C. MEDAIRY, M.D.*

This is my autobiography. It is now April 15, 1952, and I have attained my fifty-fifth birthday. When one gets that old and voluntarily divulges his age as a preliminary utterance, he is either loose tongued from "bottled-in-bond oratory" or else there is some distinguishing characteristic of his age which makes him proud and boastful. It is the latter reason for which I plead guilty and beg your indulgence on this, a unique and memorable anniversary. I am intensely human and yet with profound humility I willingly accept my earthly destiny as being of Divine Inspiration. Need I therefore apologize for my professional career which has as its founder, Christ the Divine healer, and humanity as the recipient of its charitable beneficences and skills? By the same token my life span now at 55 years becomes fuller, richer, more virile and useful in productive humanitarianism as the years accrue, and by the Grace of God, will continue as long as human life requires its ministrations in this county.

You know me in Baltimore County. Indeed I am known throughout the Maryland Free State as well as over this vast democratic nation. How well you know me, however, I am not aware.

My pre-natal life began as a product of man's greatest possession, his mentation. At the earliest moment in my gestation period I might properly have been designated as an "Idea," conceived in that intangible activity characteristic of the neuronal cellular architecture of the cerebral cortex which, for want of a better term has been called the Sensorium.

The particular sensorium in which I found my earliest being was that of Dr. Jackson Piper. In addition to those sterling qualities which are so necessary to the physician and which characterized his successful professional role in his community, Dr. Piper possessed a warmth and congeniality in his personal contacts, as aptitude for oratory and a keen sense of humor. With this type of personality integration, a sensorium can get somewhat crowded

and I knew that to gain the right to recognition and birth I would have to risk being considered a nuisance in my endeavors to bob up occasionally into his consciousness. Accordingly, I diligently studied the various tracts and commissures until I found the shortest distance to Dr. Piper's consciousness, a path which I traveled so frequently that I must have eroded it to the point of demyelination. At last on April 1, 1897, I was rewarded for my tenacity of purpose and became aware that my "birth" was near at hand for I learned that Dr. Piper sent to the physicians of Baltimore County an invitation to meet on April 15th to organize the "Baltimore County Medical Association." Their acceptance followed and I was born at 2:00 p.m. April 15, 1897. With just pride in this memorable occasion you must bear with me while I quote from the records the events of my birth and christening.

"On April 1, 1897 an invitation to the physicians of Baltimore County was issued by Drs. Jackson Piper, Towson; J. F. H. Gorsuch, Fork; R. C. Messenburg, Towson; R. Percy Smith, Sunnybrook; and H. Burton Stevenson, Riders, requesting all physicians in the County to meet them at Grange Hall, Towson, April 15, 1897 at 2:00 p.m. for the purpose of forming a County Medical Society. In response to the invitation the following physicians met at the above place and date: Jackson Piper, Towson; R. C. Messenburg, Towson; J. H. Jarrett, Towson; E. N. Brush, Sheppard Asylum; J. F. H. Gorsuch, Fork; H. Burton Stevenson, Riders; T. C. Peebles, Lutherville; William J. Todd, Mt. Washington; R. Percy Smith, Sunnybrook; William Lee, Stevenson; R. B. Benson, Cockeysville; J. E. Benson; Cockeysville; J. L. Ridgely, Rockdale; P. F. Sappington, Govanstown; L. Gibbons Smart, Roland Park.

Dr. Stevenson called the meeting to order, explained its object and placed in nomination as Temporary Chairman, Dr. Jackson Piper, who was elected. Dr. L. Gibbons Smart was elected Temporary Secretary, Drs. Messenburg, Lee, Todd, Brush and Gorsuch expressed their views as to the wisdom of forming a County Medical Society. A motion was made to appoint a committee of three to draft a Constitution and By-laws. Dr. Smart offered an amendment to make the Committee five instead of three; it was seconded and the amend-

* Historian, Baltimore County Medical Association.

ment carried. The chair appointed Drs. Stevenson, Peebles, Brush, R. Percy Smith and Messenburg, which committee retired.

Dr. Todd spoke of the business side of Medical Societies.

After an interval of some minutes, the Committee appeared with Constitution and By-laws. Before reading it, a motion was made by Dr. Brush and carried that the same Committee retire after adoption of the Constitution to name permanent officers. The Constitution and By-Laws as drafted by the Committee was then read by Dr. Stevenson, the Chairman, after which it was read by Sections, accepted, amended or altered by the association. Article I. Section I., of the adopted Constitution provides that this Society be known as "The Baltimore County Medical Association."

The Committee again retired to name officers. Dr. Brush, having left, Dr. Lee was appointed in his place on the Committee, which after consultation reported permanent officers as follows:

President:—DR. JACKSON PIPER

Vice-President:—DR. WILLIAM LEE

Secretary:—DR. L. GIBBONS SMART

Treasurer:—DR. WILLIAM J. TODD

Executive Committee: R. C. MESSENBURG; T. C. PEEBLES AND H. B. STEVENSON

Committee of Honor: CHARLES G. HILL; J. F. H. GORSUCH; R. PERCY SMITH.

All were unanimously elected for one year.

On motion of Dr. Stevenson, the Secretary was instructed to notify every member of the medical profession in Baltimore County of the time and place of the next meeting and invite them to be present. The Treasurer and Secretary were instructed to purchase what books they needed and have done whatever printing was necessary. At a late hour the Association adjourned, to meet in Towson on the third Thursday in May."

Signed: L. GIBBONS SMART, *Secretary*

I was weaned on the frivolity of the "gay nineties;" beheld the dawn of a new century and had just fallen into the prevailing pattern of indifference and complacency, born of a grandiose materialism, when I was rudely awakened by the sinister spector of the first world war. Shocked into a sober con-

sideration and evaluation of the meaning of human and spiritual values, I relaxed but reviewed with apprehension the increase of lawlessness, crime and delinquency during the "roaring twenties;" I staggered under the economic depression of the "thirties," from which I was slowly recovering only to be confronted with the dreadful curse of the Second World conflict of the "forties" in which I again took active participation; and I am now approaching the half-century mark in fear and trepidation standing on the brink of world chaos.

The present picture is heavily impregnated with such antisocial factors as distrust of neighbor, lust for power, avarice, jealousy, envy, relaxed moral code, uninhibited passions and utter disregard for the inalienable rights of others. It is frightening and we ask ourselves—have we surrendered our God-given Human dignity for the mess of pottage of unbridled Bestial instincts? One shudders to think of what widespread irresponsibility pervades a milieu entrusted as custodian to such a devastating power for destruction as atomic energy.

I have witnessed a kaleidoscopic procession of significant medical achievements in the fields of Immunology, Biochemistry, Physical Medicine, Surgery, Pharmacology, Hygiene and Public Health, Neuropsychiatry, Oncology, Therapeutics and Clinical Pathology. This presents a more wholesome utilization of man's intellectual faculty.

I am proud to be identified in a profession with such a glorious history and fortified with the strength, integrity and intellectual endowments of the renowned physicians who have been a part of my prodigious growth. I accept the challenge of the future for Baltimore County and for my State of Maryland.

ST. MARY'S COUNTY MEDICAL SOCIETY

J. ROY GUYTHER, M.D.

Journal Representative

Plans are progressing on the expansion program at St. Mary's Hospital. The architect reports that a wing adding 20 beds and the other necessary facilities will cost from \$125,000 to \$150,000. A fund raising drive is under way, and it is hoped that actual work will begin on the wing by the end of this year.



New Headquarters, Carroll County Health Department

CARROLL COUNTY MEDICAL SOCIETY

WILBUR H. FOARD, M.D.

Journal Representative

The Carroll County Medical Society met at Hoffman Inn, Westminster, Maryland, at 1:00 P.M., Wednesday, September 17, 1952. Two new members were received into the Carroll County Medical Society—Dr. Walton E. Stevens, who came to Taneytown, was received into membership at the June meeting, and Dr. William L. Stewart, who just recently moved to Westminster, was accepted into the society at the September meeting.

Two former members, Dr. W. V. Winiarz and Dr. Elizabeth Winiarz, formerly of Carroll County and Springfield State Hospital, have written that they have moved to Cambridge, Maryland. Dr. E. Winiarz is working for the State Health Depart-

ment. Dr. W. V. Winiarz is working for the Department of Mental Hygiene.

Our speaker for the meeting was Dr. Edwin Stewart, Jr., of Baltimore. A very interesting and profitable talk was given on Breast Lesions which was accompanied by colored slides.

The Carroll County Health Department has now moved from their old quarters on Main Street in Westminster into their new quarters which is located on the Washington Road, which overlooks the whole town of Westminster. The new quarters are quite spacious and up to date in every detail. The plans call for the setting up of a Branch Laboratory of the Maryland State Health Department which will occupy part of this building. Dr. Neil Gordon, the county health officer, stated that the Branch Laboratory will probably be in operation in a few months. This Medical Center was made possible by the contributions of the citizens of Carroll County as a memorial for veterans of World War II.

* * * * *

FOR YOUR INFORMATION: NAME AND ADDRESS OF 2ND ARMY SURGEON

Capitol Clinic, A. M. A., Vol. 3, No. 29, July 23, 1952

2nd Army—(Delaware, Kentucky, Maryland, Ohio, Pennsylvania, Virginia, West Virginia)—Brig. Gen. Alvin L. Gorby, M. C. Headquarters, 2nd Army, Ft. George G. Meade, Md.

BALTIMORE CITY MEDICAL SOCIETY

1211 Cathedral St., Baltimore, Md.

SAMUEL McLANAHAN, M.D., *President*
WETHERBEE FORT, M.D., *Vice-President*EDWARD F. COTTER, M.D., *Secretary*
J. ALBERT CHATARD, M.D., *Treasurer*

ANNUAL MEETING

Friday, December 19, 1952, 8:30 p.m.

BUSINESS SESSION

- | | |
|---------------------------|------------------------------------|
| 1. Report of Secretary. | 4. Report of Nominating Committee. |
| 2. Report of Treasurer. | 5. Election of Officers. |
| 3. Reports of Committees. | 6. Election of New Members. |

Abstracted reports will be distributed to the members.

JOINT MEETING WITH THE SURGICAL SECTION

SCIENTIFIC SESSION

Treatment of Certain Gastro-intestinal and Circulatory Disorders: Discussion of Controversial Medical and Surgical Measures. (Illustrated.) Keith S. Grimson, M.D., Professor of Surgery, Duke University Medical School; Surgeon, Duke Hospital, Durham, North Carolina. (By invitation.)

BUFFET SUPPER

* * * * *

HEALTH COMMISSION WITNESSES URGE MORE FUNDS, SERVICES AND FACILITIES

Capitol Clinic, A. M. A., Vol. 3, No. 28

Lay and medical witnesses, testifying at open hearings of the *President's Commission on the Health Needs of the Nation*, repeatedly stressed the need for more funds, more services and more facilities. Greater use of federal funds was recommended in several fields (see summary below). Testimony at the two days of hearings, the first to which the press was invited, came from a group of participants in earlier closed panel sessions. Commissioners questioned witnesses, but *the Commission itself took no action on the panels' recommendations*. Panel recommendations presented to the Commission included:

Rural health—A method "must be found" to finance medical education for rural youths and provide internships and proctorships in rural settings in order to develop general practitioners for rural areas. *Industrial health*—More uniform workmen's compensation laws are needed, as well as more research and training in social, occupational and environmental medicine and hygiene. *Environmental health*—Federal grants, research and information efforts should be extended to assure state and local improvement of environmental health services.

Health of the aging—Economic status of most older people is such that "adequate medical care can be provided them only through substantial use of public funds." *Care of the chronically ill*—In spite of savings from concentration on prevention, detection, control and rehabilitation, "it is probable that even larger sums, public and private, will be needed before care of chronic illness is comparable . . . to that given acute illness." *Mental health*—More psychiatric training of medical students; health groups such as Blue Cross should extend their coverage to include mental disorders. *Health of mothers and children*—Federal grants to schools for training of personnel in maternal and child health urged, including grants for students and for teachers' salaries.

Library

THE MCCLEARY FUND

Dr. Standish McCleary was born in Baltimore on January 19, 1870. After completing his preliminary education in the public schools and receiving his medical training at the College of Physicians and Surgeons of Baltimore, from which he graduated with high honors in 1890, he served as a resident at Bay View and Mercy Hospitals and, in 1894, entered private practice.

He was one of the outstanding leaders of the Medical and Chirurgical Faculty, having joined the Faculty in 1894 and for many years serving the Faculty as a member of the Council, holding the office of Vice-President in 1926.

As a member of the Faculty of the College of Physicians and Surgeons of Baltimore, he held the position of Associate Professor of Pathology and Demonstrator of Histology and Pathology and later served as Professor of Histology and Pathology. When the College of Physicians and Surgeons merged with the University of Maryland, he was elected to the position of Professor of Pathology. As a member of the College of Physicians Research Society, it has been said that for thirty years he never missed a meeting. He was held in such high esteem by his students that the 1916 yearbook of the College of Physicians and Surgeons was dedicated to him. Dr. William Royal Stokes, in describing the faculty in the yearbook, had this to say of Dr. McCleary:

"The versatile McCleary knows everything in sight

From dogs, antiques, and racing to where the fishes bite;

Bacteriologue and pathologue, clinician, sage and wit,

The only thing he does not know is how to sew and knit."

In one of the many tributes paid to Dr. McCleary, a fellow physician spoke of his devotion and fidelity to his friends, not only of his own period but also with those both younger and older than himself. He had a capacity for friendship that was rare and was kind and sympathetic, but none could be more severe in judgment of any wrongdoing in professional relations.

Dr. McCleary's skill as a pathological microscopist was well known and his authoritative opinion was often called upon for final judgment.

Before his death on November 19, 1934, Dr. McCleary requested his sister, Miss Rose McCleary, to give the sum of \$1,000 to the Medical and Chirurgical Faculty and the following is quoted from Miss McCleary's letter, which accompanied the gift: "That the income therefrom be devoted each year to the purchase of books and literature on the subject of Pathology and that if there is from time to time any accumulation of such income, it may be used by the Faculty for the giving of lectures on that subject."

Books purchased for this fund are marked, "Presented by the McCleary Fund," and the Faculty bookplate is used. We have a few of Dr. McCleary's personal bookplates, which he designed, and they are frequently on display.

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THE STOKES MEMORIAL FUND

On behalf of the Stokes Memorial Committee, Dr. Alexius McGlannan presented the Stokes Memorial Fund to the Medical and Chirurgical Faculty on April 29, 1931. The following is quoted from Dr. McGlannan's presentation address: "The interest from the Fund to be expended under the direction of the Council of the Faculty for a Memorial Lectureship on bacteriology or pathology or for books on similar subjects."

William Royal Stokes was born in Baltimore on August 21, 1870. He was educated at Deichmann's Gymnasium School and graduated in 1891 from the School of Medicine of the University of Maryland. He spent the following two years doing post-graduate work in histology and pathology at Johns Hopkins University. His zeal for knowledge in his chosen field led him to Boston, where he worked with Dr.

W. T. Councilman and became the Assistant Resident Pathologist at the Boston City Hospital under the direction of Dr. J. Homer Wright. He returned to Baltimore in 1895 and began his career of public health service. His first assignment was to reorganize the Department of Bacteriology of the City Health Department. He held the directorship of this department until his death on February 10, 1930, of psittacosis, which he contracted while performing autopsies on parrots that had died of the disease.

Dr. Stokes devoted many hours of his time to the advancement of medical education and public health. He was the Demonstrator of Anatomy at the Woman's Medical College, 1891-93; Assistant Instructor, Johns Hopkins Hospital, 1895-96; Lecturer on Bacteriology at the Baltimore Medical College, 1896-98; Associate Professor of Histology and Pathology, University of Maryland, 1898-00; Professor of Pathology and Bacteriology, College of Physicians and Surgeons, Baltimore, 1900-15. When the College of Physicians and Surgeons merged with the University of Maryland, he continued as the Professor of Bacteriology. In the field of public health he was recognized as an outstanding bacteriologist. His numerous contributions to the field of medicine were valuable and many of them were pioneer in character. In recognition of his scientific contributions, he was given the degree of Sc.D. from Washington College, Maryland, in 1910.

He was a prolific writer of scientific writings as well as poetry, an excellent teacher who possessed the rare ability to combine efficiency and charm, a distinguished scientist and a public servant, whose many years of faithful service ended in the sacrifice of his own life in carrying out his duty to protect the public. As a man he will be remembered for his kindness, cheerfulness and good fellowship.

The bronze memorial tablet in the Municipal Office Building is a lasting tribute from his fellow workers of the Baltimore City Health Department: "*William Royal Stokes, M.D., 1870-1930*
To the memory of an able physician and bacteriologist.
A lover of art, music and poetry who died a martyr
to the cause of science, contracting psittacosis (parrot fever) in line of duty."

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MEDICAL RESEARCH FELLOWSHIPS AGAIN OFFERED BY SCIENCE FOUNDATION

Capitol Clinic, A. M. A., Vol. 3, No. 34, August 26, 1952

National Science Foundation's second graduate fellowship program for academic year 1953-54 offers awards to medical students interested in careers in medical research; no awards to be made for study in clinical medicine. NSF said majority of awards under the program will be made to graduate students seeking master's or doctor's degrees in sciences. Stipends will range from \$1,400 for first year fellows to \$3,400 for postdoctoral fellows. Application forms will be available after October 1, 1952 from National Science Foundation, Washington 25, D. C. Nearly 600 fellows will be studying under the NSF program for this fall.

Health Departments

CONSERVATION OF HEARING IN THE COUNTIES

EDWARD DAVENS, M.D.*

For several years Crippled Children's Services in the State Health Department, in cooperation with an interested group of otolaryngologists and the family physician, has been interested in the prevention of deafness among children in the counties of Maryland. The principal effort has been to encourage public health coordination of the variety of services needed by children who are hard of hearing or who are suffering from conditions which may lead to impaired hearing. Interest in this problem goes back as far as 1924 when the Baltimore City Department of Education started routine hearing tests of school children and in 1927 made arrangements with a Baltimore otolaryngologist for follow-up diagnosis and treatment. In 1930 the clinical part of the program was undertaken by the Baltimore City Health Department.

Somewhat later similar action was taken in the counties of Maryland. The State School for the Deaf, cooperating with the State Department of Education undertook audiometer testing of elementary school children, but there was a considerable lag between this case finding effort and the provision of specialized clinic service. The first county clinic was started in Cumberland, Maryland, as a cooperative undertaking of the State Department of Education, the Allegany County Health Department, and the American Legion.

In 1942 the Washington County Hearing Program was inaugurated by the county health department to see what could be done on a community wide basis in the prevention of deafness. The success of this undertaking and the studies made there have helped to stimulate the growth of interest elsewhere until at the present time all of the counties have at least some of the services needed.

* Chief, Bureau of Preventive Medicine, Maryland State Department of Health.

NATURE AND EXTENT OF PROBLEM

The principle of prevention of deafness rests upon the now accepted fact that in most instances hearing impairment follows upon respiratory or ear infections in early life. Moreover, these infections are amenable to therapy by present methods. A study (1) of the Hagerstown figures showed that in four of every five children with impaired hearing, the difficulty was traceable to respiratory or ear infections. Analysis of 663 patients with hearing impairment revealed that in 83% the impairment was attributable to ear or respiratory infections. This means that in only one of every five is the deafness not preventable.

Statistics on the prevalence of hearing loss are plentiful, although variability factors have caused some difficulty in interpretation. These factors include method of testing, frequency of calibration of the instruments, criteria for screening, acoustic conditions of the testing room, presence of acute ear disease or blockage of the auditory canal, and the factors inherent in any subjective test (2). Analysis of the numerous studies supports the view of the American Hearing Society which states that 5% of children have hearing *sufficiently impaired to warrant further study*. This means that in the State of Maryland there are 17,220 school children actually enrolled in public and non-public schools who would be benefited by careful medical and audiological evaluation of their hearing status.

The best estimate of the numbers of school children whose hearing is *sufficiently impaired to require special educational measures* is from 1.5 to 3% of the enrollment (3). If we take the lower figure, this means 5,166 school children already have a handicapping loss of hearing.

In the recent Harford County study (4) from a total school population of approximately ten thousand, 995 children of school age were referred to the hearing clinic by family physicians or as a result of audiometric screening in the school. Of these cases, 161 or 16% were found to have no significant ab-

normality; 801 cases or 81% had conduction deafness; and 33 cases of 3% had nerve deafness. Among the 801 cases of conduction deafness, temporary hearing loss due to wax and acute upper respiratory infections accounted for only 89 cases. The remaining 712 had chronic deafness associated with a history of previous upper respiratory infections.

PUBLIC HEALTH ASPECTS

The hallmark of this particular disability is its essential *preventability*. Primary prevention may be achieved through better control of certain communicable diseases such as meningitis, mumps, and rubella (in pregnant women) and secondary prevention through early diagnosis and adequate treatment of infections and allergic diseases of the middle ear during preschool and early school years.

Another characteristic of this condition is the frequency of occurrence and the insidiousness of development. In the Harford study no less than 834 children or 8.34% of the total school enrollment were found to have a definite hearing impairment after careful clinical study.

Progress in the field of audiology and the remarkable development of new electronic instruments for research, clinical procedures, and individual hearing aids have tremendously widened the horizon of what can be done to prevent hearing impairment in childhood. Also improved is the chance of maximum utilization of the residual hearing by the use of new type hearing aids and the development of auxiliary methods of communication. Major advances in medical treatment include improved surgical procedures, the use of radium and x-ray, and an impressive list of new drugs.

In addition to the medical and audiological treatment, there are a wide variety of other services which are needed before it is possible to provide optimum total care for all children with hearing loss. Some of the needed services in a conservation of hearing program follow: (a) continuous observation by informed physicians, nurses, teachers, and parents for suspicious symptoms of hearing loss; (b) routine audiometric testing of school children by trained personnel; (c) diagnostic clinics employing an integrated approach between pediatrician, otolaryngologist, clinical audiologist, and speech pathologist; (d) medical and surgical treatment by family physician or specialist; (e) hospitalization;

(f) public-health-nursing services for follow-up and interpretation to the family and classroom teacher; (g) medical-social services to help in solving the numerous emotional, environmental, and social factors which interfere with treatment or acceptance of treatment in some cases; (h) psychiatric or mental-hygiene clinic services, (i) provision and fitting of hearing aids and training in their use, (j) special education services in the schools, including speech reading and speech training, and last but not least, (k) vocational rehabilitation services for job counseling, training, and placement.

In many of the more complex cases several of these services are needed by a single child in order that any one service will be effective. For example, referral to a psychiatrist or a mental hygiene clinic may be necessary, before it is possible to succeed in making best use of a needed hearing aid.

CASE FINDING

From the preventive standpoint, the early location of children with hearing loss or with conditions which may lead to it is of fundamental importance. The best method is the thoughtful observation of parents, physicians, nurses, and teachers who have developed a low threshold of suspicion for suggestive symptoms of hearing impairment. The Health Department has available a screening guide for the detection of hearing impairment in preschool children.

In the school health program screening technics are being emphasized jointly by the departments of education and health. Most effective of these methods is the so-called "daily teacher observation of school children" by the classroom teacher who is in a strategic position to note significant changes in behavior. Periodic teacher-nurse consultations is another method now in use.

A more objective method routinely used in all of the counties is the examination of school children by the pure-tone audiometer, where the audiometrist is, preferably, a specially trained employee of either health or education department. The precise selection of grades to be tested varies with local circumstances; usually alternate grades are tested every year. The test procedure is called the "sweep-check." The attenuator-control of the instrument is kept at 15 decibels. The test is begun with the frequency-selector set at 1000 cycles; if the pupil can

hear this tone (indicated by raising his index finger), the technician turns the tone control to 2000 cycles and so on up to the highest frequency. This procedure takes about a minute and a half for each child. After each class has been screened, the technician rechecks the children who have failed. These children are tested much more carefully and in much greater detail. A manual of "Recommended Procedures for Audiometric Testing" is available from the Division of Crippled Children, State Department of Health.

DIAGNOSIS AND TREATMENT

Conservation of Hearing clinics are now sponsored by all of the county health departments although the frequency varies greatly. Some of the more distant rural areas may have as little as three clinic sessions a year while the larger counties less distant from Baltimore have a more frequent schedule.

From the beginning, the clinical procedure has been greatly influenced by the work of Crowe (5), who has shown "that impaired hearing in children, whatever the primary cause, is almost invariably complicated to a greater or less degree by partial Eustachian tube obstruction, secondary to hypertrophied lymphoid tissue in the nasopharynx . . . that this lymphoid tissue may impair the function of the Eustachian tubes and cause a low grade tubotympanic catarrh, which may lead to chronic progressive deafness . . . and that this lymphoid tissue is so sensitive to radiation that the dosage employed in the treatment of the nasopharynx is far below the amount that could cause any irritation or injury to the mucous membrane, (and therefore radon treatment) may be used for the sole purpose of reducing obstructing nodules of lymphoid tissue, decreasing the secretion of mucus, and restoring the normal ventilating function of the Eustachian tubes."

Another recent and significant influence in the clinical setting has been the introduction of teamwork between the otolaryngologist and the clinical audiologist. The latter may be defined (6) as the specialist who "treats communicative disorders caused by hearing disability. This is rehabilitative treatment designed to help the individual achieve optimum results in the use of communicative skills; the specific clinical objective is to help him learn

new communicative skills to supplement or supplant his faulty hearing mechanism. So far as permanent hearing disability is concerned, the point of treatment is not the ear alone but the whole person, his psychosocial behavior, his use of language, and his ability to take a normal part in his community to the extent of his potentialities. Because a permanent hearing disability (usually generalized as a hearing loss in excess of 35 decibels for the speech-hearing function) interferes with normal communication, it usually involves behavior changes that are detrimental to the individual's well being."

From the otologic standpoint the principal emphasis is placed on accurate diagnosis of the type and cause of the defect in the hearing mechanism and the choice of medical or surgical therapy which will restore the function of the ear or prevent further extension of the pathologic process. Diagnosis includes a careful history; ear, nose, and throat examination; nasopharyngoscopic visualization; and tests involving pure-tone and speech audiometry as well as the classical tuning-fork tests. Radon irradiation of the nasopharynx when indicated (approximately 45 per cent of cases) is the only treatment performed in the clinic.

For other needed therapy the patient is referred to the private physician. Most frequent recommendations for treatment include tonsillectomy and adenoidectomy, mastoidectomy, sinus surgery, submucous resection, and management of allergic disease.

Every effort has been made to achieve thoughtful community planning both prior to establishing this program and on a continuing basis. In the case of school-age children, details of case-finding procedures, notification of parents, clinic appointments, follow-up by the public health nurse, special education in the school and vocational rehabilitation services are worked out by the county health officer and the superintendent of schools. Policies regarding such matters as radium treatment in the clinic, notification to private physicians of diagnostic findings, referral recommendations to the family physician for therapy, financial assistance with hospitalization and surgical treatment for patients unable to pay are all discussed and mutually agreed upon by the county medical society, county health department, and the otolaryngologist who conducts the hearing clinic.

A close working relationship has been established between the county hearing program and the audiological center at Johns Hopkins Hospital—the Speech and Hearing Center. Cases requiring more intensive audiologic work-up are referred, particularly young preschool children, those with organic brain damage, and those with questionable hearing loss (psychogenic deafness). The use of the new objective psycho-galvanic audiometry has been invaluable in providing a more accurate diagnostic appraisal. When a hearing aid is indicated, this is carefully fitted by various tests without commercial implications. Special auditory training is then instituted in order to teach the child and his parents how to use the aid, and limited psychotherapy is used to help him in the adjustment. For more severe emotional problems or psychogenic deafness, psychiatric consultation is requested. In order to compensate further for his hearing loss the child and his parents are introduced to the principles of speech reading. The mastery of this technic, of course, takes several years and must be continued by special teachers in the school.

SPECIAL EDUCATION AND VOCATIONAL REHABILITATION

Concurrently with the development of case finding measures and provisions for diagnosis and medical follow-up the schools have been quick to see the need for adding qualified speech correctionists to the staffs of the county schools, so that assistance can be given to the classroom teacher and special tutoring to individual pupils who need help to overcome the handicap imposed by hearing loss and the associated speech difficulty. There are now about twenty such speech correctionists employed in the county schools where just a few years ago there were none.

After all medical measures have been tried, there are found to be a number of children who continue to have some residual communicative disability. These boys and girls need vocational rehabilitation services, including counseling and guidance, voca-

tional training, compensation adjustment, maintenance during training, and placement in employment. For this purpose prompt referrals are made at the age of sixteen years to the Vocational Rehabilitation Service in the State Department of Education.

SUMMARY

A brief description of the purpose and content of the County Conservation of Hearing program has been given.

Attention is drawn to the primary focus on prevention of hearing impairment rather than salvage of handicaps which need never have occurred.

An estimate of the numbers of Maryland school children with hearing impairment is suggested, and the point is made that recent studies in Harford County indicate that the estimate may be too low.

The case-finding value of observation by alert and informed parents, physicians, teachers, and nurses is stressed, and the method of audiometric testing in the schools is described.

The part played by the diagnostic hearing clinics and the close working relationship with the audiological center in Baltimore are outlined.

The variety of auxiliary services needed by children with hearing loss is described and special mention is made of special education in school and vocational rehabilitation.

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STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 3-30, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARA- LYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County.....	5	—	1	1	2	—	3	7	—	7	—	—	1	15	—	15	—	5
Anne Arundel.....	2	—	—	—	1	—	1	2	—	2	—	—	—	4	—	8	—	1
Howard.....	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Harford.....	1	—	—	—	—	1	1	—	—	—	—	—	—	6	1	—	m-2	1
Carroll.....	2	—	—	—	2	—	—	1	—	—	—	—	—	—	2	2	—	—
Frederick.....	6	—	1	—	9	—	1	7	—	9	—	—	—	2	1	1	—	—
Washington.....	4	—	—	—	—	—	—	1	—	—	1	—	—	10	—	—	—	1
Allegany.....	1	—	—	—	—	—	—	—	—	—	—	—	—	3	—	—	—	2
Garrett.....	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—
Montgomery.....	4	—	1	—	1	1	6	11	—	3	—	—	—	10	—	1	—	4
Pr. George's.....	2	—	1	—	—	1	3	6	—	1	—	—	2	12	1	4	—	2
Calvert.....	—	—	—	—	—	—	—	—	—	—	—	—	—	4	—	—	—	1
Charles.....	1	—	—	1	—	—	—	—	—	—	—	—	—	1	—	1	—	—
Saint Mary's.....	—	—	—	10	—	—	—	—	—	2	—	—	—	2	—	—	—	—
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	1	—	3	—	—	—	1
Kent.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1
Queen Anne's.....	—	—	—	4	—	—	—	1	—	—	—	1	1	1	—	—	—	—
Caroline.....	—	—	—	—	—	—	2	—	—	—	1	—	—	—	—	3	—	—
Talbot.....	—	—	—	1	2	—	—	—	—	—	—	—	—	1	—	—	—	2
Dorchester.....	1	—	—	—	—	—	2	—	—	—	—	—	—	—	1	2	—	1
Wicomico.....	2	—	—	—	—	—	—	—	—	—	—	—	—	4	—	7	—	1
Worcester.....	—	—	—	—	—	—	—	1	—	—	—	—	—	3	—	—	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	1
Total Counties.....	31	0	5	17	17	3	19	37	0	24	3	2	4	83	6	45		24
Baltimore City.....	20	0	1	6	10	1	19	10	0	32	1	0	6	93	11	639	c-1	14
State																		
Oct. 3-30, 1952.....	51	0	6	23	27	4	38	47	0	56	4	2	10	176	17	684		38
Same period 1951.....	55	1	8	8	285	3	39	18	1	50	1	1	30	210	26	690		34
5-year median.....	47	8	3	—	22	5	34	29	1	43	4	2	87	188	80	651		38
Cumulative totals																		
State																		
Year 1952 to date.....	2790	8	842	207	9100	77	957	174	29	902	20	15	177	2304	169	7380		552
Same period 1951.....	2775	35	854	201	5700	49	3621	67	40	791	17	25	391	2320	277	6382		416
5-year median.....	3093	164	388	—	2936	102	1247	133	56	936	31	36	1119	2349	1095	6505		562

c = congenital syphilis under 1 year of age.

m = malaria contracted outside the U. S. A. reported by Aberdeen Proving Grounds, residence not stated.

There were no significant changes in the incidence of communicable diseases during the 4-week period ending October 30, 1952.

Blue Cross and Blue Shield

BLUE CROSS AND BLUE SHIELD

REGINALD H. DABNEY*

There has been much discussion of the service benefit feature of Blue Shield—what it means, how it operates, whether it is good or bad. This unique feature of the Blue Shield Plan is one of its most important elements and is the single factor which differentiates it from commercial insurance.

Like its companion Blue Cross in the hospital field, Blue Shield is incorporated as a voluntary, non-profit organization to provide medical care to the citizens of the community. Its establishment here and throughout the nation stems from the need to protect the individual family, especially in the middle and lower income brackets, from the often disastrous impact of large medical expenses. The agreement by the participating physician that he will accept a specified amount as payment in full for his services to subscribers in the middle and lower income levels enables this group to budget their medical care through a prepayment program, thus minimizing the financial effect of unexpected illness. For persons in higher income brackets, the benefits provided help tremendously in meeting medical bills.

The public acceptance and demand for Blue Shield is best evidenced by the phenomenal growth in membership since the end of World War II. In December 1946, there were 1,800,000 subscribers in all Blue Shield Plans; in June 1952, there were 23,000,000 members in the country enrolled through seventy-eight Plans sponsored by state and county

* Executive Director, Maryland Hospital Service, Inc. and Maryland Medical Service, Inc.

medical societies. All of these Plans must meet certain standards for approval established by the Council on Medical Service of the American Medical Association, and membership standards adopted by the National Association of such Plans, the Blue Shield Medical Care Plan Association.

Obviously, the establishment and success of a service benefit Plan rests primarily with the physicians in the local area who sponsor and participate in the program. The increasing recognition of the need for the service feature is evidenced by the fact that today, sixty out of the seventy-eight Blue Shield Plans are operating on this basis, with income ceilings ranging up to \$6,000, and a majority of the eighteen Plans still on an indemnity basis are seriously considering the addition of service benefit provisions.

Basically, your Blue Shield Plan is a community service program, under the control of the physicians in the State, and with public representation on its governing board. Every licensed doctor of medicine has the right—and is urged—to participate, the subscriber is at all times free to choose the doctor who will serve him, and the personal relationship between the patient and the physician is maintained. Any program of this kind designed to serve a great number of people has its shortcomings and problems, but these can be reduced and eliminated through cooperative effort over a period of time. The fact remains, as Dr. Houston Everett said in his statement in the July issue of the *Journal* entitled "Support the Blue Shield," that "... the profession of the State has again taken a constructive step in combatting the threat of socialized medicine."

* * * * *

PUBLIC HEALTH SERVICE DOCTORS LOSE MILITARY STATUS

Capitol Clinic, A. M. A., Vol. 3, No. 29, July 23, 1952

Deletion of a section of the Emergency Powers Continuation bill in the closing days of Congress has shifted members of the commissioned corps of Public Health Service from military to civilian status. According to the PHS legislative representative, the change will mean that PHS doctors will be denied (a) uniform allowances (b) survivors benefits (c) death gratuity and (d) all other military benefits not specifically provided by law under the PHS Act. However, they will continue to receive the special \$100 per month pay, may still discharge their military obligation by service in PHS and may not now be required to remain in PHS.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

SEMIANNUAL LEGISLATION REPORT

MRS. H. HANFORD HOPKINS, *Chairman*

The Keogh-Reed Bill, now before the House of Representatives, deserves our enthusiastic support! It represents an effort to alleviate the unfair tax burden carried by doctors and the other independent citizens who, by their own request, were not placed under "Social Security."

According to the provisions of the Bill, self-employed individuals such as doctors, lawyers, dentists, and farmers, may set aside in a trust fund a *certain percentage* of earned income each year. This has the immediate effect of reducing their current income tax! The trust fund, however, must remain inviolate, except in cases of total disability, until the individual reaches the age of sixty-five years. At sixty-five an income tax would be paid on the trust fund at the prevailing rate.

If you and your husband approve of the Keogh-Reed Bill write to your Representative in Washington in favor of it! Good legislation with a positive approach to economic problems is rare and is worthy of action on our part!

The following newspaper article by George E. Sokolsky explains the imminent danger of that insidious thing, legislation on an "international" plane, by which American Fabians and other people who wish to plan our lives, seek to supersede our Constitution and National Sovereignty, so that they can impose socialism, and other degrees of communism on us from without against our will.

"SOCIALIZED MEDICINE BY TREATY"

"At the meeting of the International Labor Organization in Geneva, Switzerland in June a convention entitled "Minimum Standards of Social Security" was passed. This convention was submitted to 65 countries, including the United States, for ratification. Once ratified by any country the convention

becomes a treaty binding that country to its provisions.

HOW IT BECOMES LAW

Under the American Constitution, if two-thirds of the members of the United States *Senate*, only, present ratify such a convention, it becomes the law of the land, taking precedence over any domestic law passed by Congress or by any State legislature.

The United Nations and an increasing number of *international* organizations, passing conventions and covenants, are really for the American People without their knowledge of what is being done to them.

This convention establishes universal socialized medicine.

Part II of the convention contains the following provision:

"Each member for which this part of this convention is in force shall secure to the persons protected the provision of benefit in respect of condition requiring medical care of a preventive or curative nature.

"The contingencies covered shall include any morbid condition, whatever its cause, and pregnancy and confinement and their consequences."

This is state medicine. The document is a long one. It is clear that should the United States ratify this convention, government hospitalization, government-controlled attendance of physicians, and government-provided medication would be required by law. Oscar Ewing's measures, which Congress has rejected, would become law, without an act of Congress so providing, but by the ratification of a treaty, the title of which does not indicate its nature. It could be passed without Senators even reading it.

DOCTORS OBJECT

Doctors all over the world objected to these provisions.

Most of the American Government delegates followed the lead of the labor delegates in voting for socialized medicine. Their argument seemed to be

that if they voted differently they would be accused of being personally *antilabor*.

This measure may come before the Senate at its next session and requires scrupulous scrutiny and fearless opposition."

AUXILIARY NEWS

Three resolutions were passed by the Woman's Auxiliary to the Medical and Chirurgical Faculty at the Semiannual Meeting. They included (one) advocating active Auxiliary support for the American Medical Education Foundation, (two) pledging Auxiliary help to The Ballot Battalion in getting out the vote, and (three) a vote of thanks to the doctors' wives of the Eastern Shore who, for the *second time*, worked so hard to make our meeting a success.

The Woman's Auxiliary to the Montgomery County Medical Society held their Autumn Dance at the Kenwood Country Club, in Bethesda, on October the twenty-first.

The Woman's Auxiliary to the Baltimore City Medical Society reports that Mrs. Howard B. Mays secured the use of doctors' offices as places for voting parents to leave children while they went to the polls on November fourth.

Mrs. Edwin H. Stewart, Jr., Chariman of Nurse Recruitment for the City Auxiliary proposed the making of a film featuring the Baltimore Hospital Schools of Nursing to a meeting of Hospital Directors, Directors of Nursing and members of the Medical Society, on September nineteenth. Her idea was favorably received and an Executive Committee is now working on details of costs, etc., which are probably to be divided among the participating hospitals.

Mrs. Henry W. D. Holljes, Co-Chairman on Nurse Recruitment for the City, has sent a letter to each hospital Auxiliary in Baltimore suggesting that perhaps they could increase their hospitals' supply by providing a Hospital Day-Nursery for their pre-school children, by pooling the work and hours of part time nurses, and by polling all their graduates,

or nurse employees, as to which hours they *could* give to duty. Mrs. Holljes included an article from the June issue of the Maryland State Medical Journal on the establishment of a day-nursery for nurse's children at the Washington County Hospital, data from The Board of Education, and a list of recommended books on the subject, with her letter. She felt that these tools would assist any Hospital Auxiliaries interested in the program.

AMERICAN EDUCATION

Any Auxiliary or other organization dedicated to American principles of government would enjoy a meeting featuring the slapboard presentation of The Freedom Forum given by the Junior Association of Commerce, American Opportunities Committee! If you belong to any group that wants a program that is dramatic, compelling and full of encouragement, write to Mr. J. Ross Myers, III, American Opportunities Committee, Junior Association of Commerce, 22 Light Street, Baltimore 1, Maryland. Mr. Myers explains why no "ism" can offer anything approaching the way of our fathers. He will inform you whether the Freedom Forum presentation, "This Is Our Problem" is available through your local Junior Association of Commerce, or may send a speaker, where possible, from Baltimore. He spoke at the October first meeting of the City Auxiliary, and many members have asked whether he would speak to other organizations.

If you want to help insure America's future in our schools read the new economics text "Understanding Our Free Economy" and see that it is placed in *your* high schools! It is the first widely admired, scholarly, book to penetrate the Fabian front and expose the failures of Socialism in the New Deal and Fair Deal!

Required reading for Americans,—have you gotten around to Whitaker Chambers' "Witness"? It is a literary masterpiece as well as a call to "eternal vigilance" for us all.

Maryland

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EDITORIAL

A MESSAGE FROM THE PRESIDENT

Hail and Farewell!

To the Members of the Medical and Chirurgical Faculty of the State of Maryland:

In April of this year I had the opportunity formally to say "Hail" to you, and to express my profound gratitude for the honor which you bestowed upon me in electing me President of your organization. Now that the year for which I was elected has nearly run its course, it seems not inappropriate that I should bid you farewell and again convey to you my sincere appreciation for your kindness to me. Since there is no formal occasion of the Faculty in the offing, at which I might make this conveyance in person, I have availed myself of the kind invitation of your Editor to use the columns of the Journal for my purpose.

Let me say at once that I do not propose to render any report of what I have done while in office, although to do so would be comparatively easy, since I have really done so very little. Indeed, there is comparatively little for the President of your society to do, because the other officers and the headquarters staff all carry out their tasks so efficiently that there is practically no space left on the wheel to which he can put his shoulder. The day-to-day business is taken care of by the devoted staff, the Council in its

wisdom handles the knotty problems that involve matters of policy, and about all that is left for the President to do is to preside at the two meetings of the Faculty and appoint committees. Unlike the immortal policeman of the Gilbert and Sullivan operetta, his lot is truly a happy one!

The happiest part of your President's lot to my way of thinking, however, arises not from the fact that he has little to do, but from the fact that he has an opportunity to get better acquainted with his fellow physicians from all parts of the State. At least it was for me, and my only regret is that I was not able to make the acquaintance of each and every member of the Faculty.

I am sure that I do not need to remind you that after all you members of the Faculty *are* the Faculty; the officers are *your* servants, the building is *your* home, the Faculty will be whatever *you* choose to make it. Now more than one hundred and fifty years of age, it has an honorable past in which all of us may justifiably take pride. It has a high tradition of devotion to the

welfare of the sick people of Maryland. It seeks no advantage of its own. To maintain its stature and high purpose is the responsibility of all of us, and in bidding you farewell as your outgoing President may I not only express once more my abiding gratitude to all of you for your kindness to me, but also my hope that in the new year

which is almost upon us the Faculty will, through the united efforts of all of us, become an even stronger organization and an even better force for good in our beloved state.

And finally, may I wish you all a very Merry Christmas and a very Happy New Year!

ALAN M. CHESNEY, M.D.

PRESENTATION OF THE PORTRAIT OF J. HALL MASON KNOX, Jr., M.D.*

Dr. Chesney†: The next number on the program is a presentation of a portrait of the late Dr. J. H. Mason Knox, Jr. Dr. D. C. Wharton Smith will present the portrait, and I consider it particularly appropriate that the family of Dr. Knox, who are presenting this portrait to the Faculty, should have selected Dr. Wharton Smith who was associated with Dr. Knox for 35 years.

Dr. Smith: *Mr. President, Fellow Members of the Faculty, Ladies and Gentlemen:* I am very happy that the children of the late Dr. J. H. Mason Knox, Jr., have asked me to present this portrait. Doctor Knox was so modest that I am sure he would disapprove if I mentioned too many of his accomplishments, so I shall only give you a brief summary. However, as this presentation will be printed in the archives of our Faculty, I am compelled to dwell on some of the facts. By so doing future historians will find the necessary data concerning the medical leaders of our state during the first half of the twentieth century.

Doctor Knox, a native of Philadelphia, died in his eightieth year, born in 1872 the son of a Presbyterian minister, who later became president of Lafayette College.

From an educational standpoint, he received degrees from Dickinson, Lafayette, The Johns

Hopkins, and Yale. Also the University of Lima, in Peru, made him an honorary member of their Medical Faculty.

He was an active member of the staffs of many of our hospitals, and a member of many local and national medical societies. He was especially active at the Union Memorial Hospital, and The Johns Hopkins Hospital, where he taught for many years. He was one of the early presidents of the "American Pediatric Society" and in 1921 just before he went abroad, he was vice-president of this Faculty. He would have unquestionably been elected president had he remained in Baltimore the following year.

In 1900, Doctor Knox became medical director of the Thomas Wilson Sanatorium for children. Here he brought sickly infants suffering mostly with the serious summer diarrheas and dysenteries. Here he did much research work and made many valuable contributions to numerous medical publications. He was unquestionably one of the early pioneers in improving the treatment of these ill infants, who previously had little hope of survival.

Doctor Knox *founded* and served for many years as *president* of the Babies Milk Fund Association. This piece of work is now administered as a part of the Well Baby Clinic by our City Health Departments.

During World War I, Doctor Knox served as a major in the Foreign service of the American Red Cross. After returning to this country where

*Transactions, 1952. Portrait presented during the Annual Meeting on Wednesday evening, April 30, 1952.

† President, Medical and Chirurgical Faculty, 1952.

he remained for three years, in 1921 he was appointed "Field Director" of the American Red Cross with headquarters in Paris, France. This appointment had international significance. He traveled widely through Central Europe and organized aid for the famine-stricken children of these countries. He set up Child Health centers in the countries newly created by the Versailles Treaty—these units cooperated with the other countries under the Health Section of the League of Nations. It is interesting that this was the only section of the League which had any real success.

Returning to Maryland in 1922, Doctor Knox was appointed "Chief of the Bureau of Child Hygiene of the State Department of Health," and served twenty years, assuming the title of consultant on his retirement in 1942. While Chief of this Bureau, he was closely associated and lectured regularly at The Johns Hopkins School of Hygiene and Public Health.

Doctor Knox was a staunch Presbyterian who lived up to his ideals and served actively as an Elder in the First Presbyterian Church. He was

a devoted father to a devoted family. His sense of humor was keen and often paved the way for a closer association. He played tennis with an intimate group of cronies. To those around him he was kind and considerate, quick to give credit to others. He helped many young doctors get their start in life. Anyone associated with him was bound to become a better citizen.

Mr. President, it is a great honor that on behalf of Doctor Knox's five children, Katherine Cutts; Mason Knox, 3rd.; Gordon Knox; Helen Miller; and Margaret Harvey; to present to the Medical and Chirurgical Faculty, this portrait of the late Dr. J. H. Mason Knox, Jr.

Dr. Chesney: On behalf of the Faculty I accept with great pleasure this portrait of Dr. Knox which I assure you will be hung in an honored place in this building. Will you convey or perhaps I may convey now to the members of his family our deep gratitude and appreciation for their generous gift, and Dr. Chatard, since you have just been appointed Curator of the Faculty, I charge you here and now with the responsibility of taking care of this portrait.

DUES—A REMINDER

American Medical Association Dues

The Council ruled, at its meeting on April 28, 1952, that the bills for the American Medical Association should be mailed with the bills to the members of the Baltimore City Medical Society and with the notices regarding dues to the members of the other Component Medical Societies.

Each member is reminded to make the check for twenty-five dollars (\$25.00) *payable to the American Medical Association*, covering the dues for the National Association, and mail to the office of the Medical and Chirurgical Faculty.

Local and State Society Dues

Dues are sent direct to the office of each Component Medical Society and then the portion which covers State Association dues is forwarded to the Medical and Chirurgical Faculty by the Secretary of the local Society.

You are urged to pay your dues promptly so they will reach the Faculty office by January 31, 1953 to insure receiving Physicians' Defense.

Scientific Papers

GERIATRICS IN GENERAL PRACTICE*

WINGATE M. JOHNSON, M.D.†

Your program chairman, Dr. Compton, is evidently a skilled fisherman. This I learned from the manner in which he hooked me for this afternoon's program. First he called me over long distance and offered as bait the delights of Ocean City. The bait was flavored—or colored—with judicious flattery to make it even more alluring. Next he confirmed the invitation by letter and asked if I would need any audiovisual aids. Guilelessly I replied that I would not, and that I expected to talk informally from an outline. Then he sunk the barb deeply by informing me that this was the Trimble Lecture, and that it should be submitted for publication in the *Maryland State Medical Journal*. It was too late then for escape, but I was not an unwilling captive, and gladly agreed to put the outline of my remarks into manuscript form.

Seriously, I do appreciate more than I can say the honor of this invitation, and the privilege of renewing old friendships and making new ones.

It is natural for medical men to become particularly interested in conditions with which they themselves are afflicted. Certainly my own interest in the problems of old age has increased as I have become more personally acquainted with them. Another stimulating factor has been the steadily increasing number of older people in the population. One authority on the subject said at a state-wide conference on aging held in North Carolina last year that old age was becoming as popular a subject as sex. The increasing age of our population is of tremendous importance from the sociologic, economic, and political, as well as from the medical, viewpoint. Only the medical aspect of the problem is to be

considered now, however—and that somewhat sketchily.

Geriatrics, the branch of medicine which deals with the care of older people, is one of the youngest medical specialties. For at least two reasons, it is not likely that many physicians will ever limit their practice exclusively to that field. The first reason is that many, if not most, elderly people resent being considered old and would not like to advertise their age to the world by going to an "old folks' doctor." The second and more important reason is that the best time to prepare for old age is in the full vigor of maturity; hence the general practitioner or internist is the logical one to practice geriatrics—which, even more than pediatrics, may be considered a "specialty" of general practice.

Already a considerable "literature" on the subject of aging has accumulated. Among the publications which can be recommended are *Geriatric Medicine*, edited by Stieglitz¹; *Care of the Aged*, by Thewlis²; *Diseases in Old Age*, by Monroe³; *Problems of Ageing*, by Cowdry⁴; and the monthly journal *Geriatrics*, edited by Walter Alvarez and published by Lancet, Inc., at Minneapolis, Minnesota.

At the outset of this discussion, it is pertinent to state what part of the life span is being considered as "old age." One of the most satisfying definitions of old age is "just 20 years older than you are," but it is hardly scientific enough for this group. Victor Hugo has said that 40 is the old age of youth; 50, the youth of old age. Stieglitz¹ accepts Hugo's criterion: "It is pragmatic to consider that the majority of the problems peculiar to geriatrics start at about 40, the approximate meridian of life." He modifies this

* I. Ridgeway Trimble Lectureship presented at the Semi-annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland at Ocean City, Maryland, Friday, September 12, 1952. (1952 Transactions.)

† Professor of Clinical Medicine and Director of the Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

statement, however, by calling attention to the obvious fact that individuals differ widely in the rate at which they age.

GENERAL CONSIDERATIONS

Of prime importance in caring for older patients is the avoidance of radical changes in diet, environment, or habits. As Mark Twain said, "Habit is habit, and not to be flung out of the window by any man, but coaxed downstairs a step at a time." Another sound rule is not to overtreat the older patient. The parting advice given successive classes at Jefferson by the late Hobart A. Hare applies especially to the care of older people: "For God's sake, let the patient get well. If you don't do any good, be sure you don't do any harm."

Hospitals

Although there is far less prejudice against hospitals now than formerly, older patients are still apt to fear them. Unless there is some real indication for hospital care, they are likely to sleep and eat better in the familiar surroundings of their own homes. When, however, it is necessary for older patients to be treated in a hospital, the resident and nursing staff should be encouraged to pet them as they would children. The prescription ordered by the late Dr. Emmett Holt—"tender, loving care"—is often needed for older patients as well as for children. I have seen old people as well as children actually shed tears when leaving a hospital.

Surgery

With improvements in anesthesia and in both pre- and post-operative care, surgery in older patients is now far less hazardous than it was only a few years ago. Not long ago I had a patient 75 years old who could have passed for a man 10 or 15 years younger. He had worn a truss for a simple inguinal hernia for 25 years because a doctor had told him when he was 50 that he was too old for surgery. In contrast was another patient nearly 70 who had a bilateral

herniorrhaphy and a kidney stone removed through a flank incision—three operations within four weeks—17 years after a severe myocardial infarction. Another at 82 had a gallbladder full of stones removed, and another at 91 had half his stomach resected for cancer. Each made a good recovery. Such examples might be multiplied over and over.

Dr. Howard Bradshaw, Professor of Surgery at the Bowman Gray School of Medicine, has said that "the most common conditions in older patients requiring operation are appendicitis, gall stones, prostatic disease, hernia, cancer, uterine procidentia, amputations for gangrene, and fracture of the femoral neck."⁵ Our surgical department is losing some of its early enthusiasm for intravenous fluids, which should be given to elderly patients cautiously, if at all. Dr. Bradshaw stated that the subcutaneous route is safer than the intravenous one, and that "Unless the patient is definitely dehydrated, he rarely requires more than 1000 cc. of fluid per 24 hours. We prefer to have them definitely on the dry side than on the wet side."

Let me offer, with approval, a final quotation from my colleague, Dr. Bradshaw: "It is a mistake in any preoperative study of the aged to indulge in prolonged expensive maneuvers aided by many consultants—all of which alarm the individual. Decision as to necessity for operation can usually be made quickly, even though definitive diagnosis may not be evident. Necessary preoperative evaluations can be done without a waste of time, and it is for the best interest of the patient that they be so done."⁵

The modern practice of getting patients out of bed soon after operation is especially helpful to older patients, since they are more susceptible to venous stagnation with consequent embolism.

With modern surgical techniques and anesthetics, there is no reason to deny older patients the benefit of a necessary operation, or of one that will make their last years much more comfortable. It is good judgment, however, to do such non-emergency operations as herniorrha-

phies, perineal repairs, and the removal of gallstones in younger life.

Exercise and Recreation

During World War I, Walter Camp boasted that he kept Woodrow Wilson's Cabinet in prime physical condition by his famous "Daily Dozen" exercises. One member of that Cabinet steadfastly refused to take the exercises. He was Josephus Daniels, who outlived all the others by many years, and died after a brief illness at the age of 85. Walter Camp himself died at 65. Chauncey Depew, who lacked only 18 days of living to his ninety-fourth birthday, was quoted as saying that he got his exercise by acting as pallbearer for his friends who took exercise.

These stories are not intended to discourage exercise within reason—but as a reminder that in later life it should not be too strenuous. After 40 golf is better than tennis—and even it can be overdone. Older people need recreation more than exercise. Every business and professional man should have some free time each week for recreation, and frequent week-end vacations, used judiciously, are desirable. Hobbies should be cultivated diligently.

INFECTIOUS DISEASES

Thanks to the advances in sanitation, to immunization, and to chemotherapy and the antibiotics, infectious diseases are of secondary importance as a cause of death at any age. An impressive proof of this fact is a comparison of the annual death rate from medical ailments among the armed forces in World War I (15.6 per 1000) and World War II (0.6 per 1000)—a decrease of 95 per cent.⁶

With advancing years, a relative immunity to many infections is acquired; but second attacks of childhood diseases—especially pertussis—are by no means rare. Childhood diseases are apt to be more severe in old patients. I once had to treat measles occurring in representatives of three generations in the same household. The grandmother died of bronchopneumonia.

It should be remembered that the virus of herpes zoster is capable of transmitting chicken pox. I had this happen once in my experience.

Tuberculosis in the older patient is too often ascribed to chronic bronchitis or the old fashioned "phthisic." A grandparent or an old house servant with this disease may live out his own expectancy but infect youngsters who come in contact with him. In the older age group there are about twice as many men as women infected with chronic tuberculosis.⁷

Pneumonia, once described by Osler as the friend of the aged because it carried them off quickly and painlessly, is now an infrequent cause of death in old people. The sulfonamides and the antibiotics have enabled many a victim of paralysis or heart disease to overcome what would once have been a fatal "terminal pneumonia."

Infections tend to produce less violent reactions in older patients than in younger ones. The elevation of temperature is less or absent, the white blood cell count lower, and chills less violent; but prostration is more marked.

Treatment

The treatment of infections is virtually the same in older patients as in the young, but less sedation is required. Stieglitz⁸ advises that for each five years of life a day longer should be allowed for rehabilitation. I am not ready to accept this rule, since it would penalize me too severely in my annual upper respiratory infection. The older patient should be turned frequently, and should not be kept in bed too long.

One warning which applies to the treatment of patients of any age, and which can hardly be overemphasized, concerns the abuse of antibiotics and sulfonamide drugs. It is hardly necessary to list the dangers associated with the indiscriminate use of these life-saving remedies. In the treatment of uncomplicated viral infections, especially the common cold, their use is apt to do far more harm than good.

One simple procedure which is helpful in de-

ciding whether or not to use one of these agents is a total and differential leukocyte count. In a patient with an upper respiratory infection who has persistent fever and rales in the chest, penicillin or one of the other antibiotics will probably be helpful if the total white count is elevated and the polymorphonuclear content is increased. If the count is normal or low and the polynuclears are not increased, it is probable that the infection is still viral. Aureomycin or terramycin might be of value in such cases, but penicillin and the sulfonamides would be of psychologic benefit only. Too many cases of bone marrow depression following chloramphenicol have been reported for this drug to be used without good reason.

Cortisone and ACTH should be administered with even greater caution than the chemotherapeutic agents. Personally I feel that one should exercise the same care in prescribing a course of sulfonamide drugs, antibiotics, cortisone or ACTH as in advising a major operation.

SPECIAL SYSTEMS

The Nervous System

In later life, symptoms referable to the nervous system are more likely to be on an organic basis. Since time will not permit a discussion of all the disorders of the nervous system, I will consider only one—a condition which is frequently overlooked, but which is perhaps the most important organic disease of the central nervous system. That condition is cerebral vascular disease, often leading to thrombosis of cerebral vessels.

It is estimated that 90 per cent of cerebral vascular accidents are due to thrombosis,⁹ the remaining 10 per cent being divided between hemorrhage and embolism. The majority of these vascular accidents occur in the so-called silent areas of the brain, and because they do not produce neurologic evidence of paralysis or even positive Babinski or Hoffmann signs, they are often overlooked. Dr. Walter Alvarez has written

and talked for years about the insidious effects of cerebral thrombosis, and from him I have learned to be increasingly aware of the frequency of the condition.

Most often the patient gives a chief complaint of "indigestion," which is characterized by upper abdominal distress, loss of appetite and weight, and bloating after meals. Careful questioning usually elicits the history of a sudden onset, generally associated with dizziness, perhaps momentary loss of consciousness or at least faintness, nausea with or without vomiting, and persistent anorexia. The patient himself may say that ever since then his memory has been poor, he continues to be dizzy, and tires easily. From the family or close friends one often learns that the patient has had a marked personality change since the onset of his symptoms. The blood pressure is apt to be lower for a long time or indefinite period after the attack.

The prognosis for recovery is not good, but is not altogether hopeless. Some patients make surprisingly good comebacks, but in the majority the symptoms are apt to persist. I have found that most of these patients will accept the explanation that one of the small vessels in the brain has been blocked by a clot, and that this has caused some irritation of the nerve which supplies the digestive apparatus. It is the part of kindness to avoid the use of such words as "stroke," "hardening of the arteries," and "arteriosclerosis" in talking with the patient, although the family should be told more frankly just what has happened, and warned not to expect too much improvement. Usually both the patient and his family are relieved to know that he does not have cancer.

The treatment for Alvarez's "silent stroke" is not too satisfactory. Dr. Alvarez himself uses some form of iodine, which has stood the test of time. Although he believes that nicotinic acid is ineffective, I prescribe it more often than any other medication, usually in doses of 100 mg. three times a day before meals. I may be in-

dulging in wishful thinking, but it seems to me that the appetite and mental outlook of many patients improve on this medication. A high vitamin, high calorie diet is also helpful. This may have to be given in several small feedings daily, since the patient is apt to feel full after a few mouthfuls.

Patients who have a definite paralysis resulting from a cerebral vascular accident may be encouraged by two case histories. The first is the famous case of Pasteur, who suffered a severe hemiplegia 27 years before his death, made a good recovery, and did much if not most of his best work afterwards. The other is that of a patient of mine, whose family told me that when he was 45 years old he had a hemiplegia so severe that he had to be fed through a tube for several days and was in bed for a month. He recovered except for a slight limp, and died of bronchopneumonia at 91—46 years later.

The Cardiovascular System

Diseases of the cardiovascular system are now the major cause of death. Arteriosclerosis, the common denominator of many degenerative diseases, is apt to affect one organ more than others. Particularly vulnerable are the brain, the heart, the kidneys, and the pancreas.

Coronary heart disease is now robbed of much of its terror. Paul White has recently said: "In my own experience, angina pectoris and myocardial infarction are so common that I have come to consider them as almost normal events in the life of the average American male. Many times I have followed patients who are perfectly well 10, 15, and 20 years after having been temporarily incapacitated by angina pectoris and coronary thrombosis."¹⁰ Dr. White stresses the importance of optimism in dealing with such patients. Not long ago a patient who had had a myocardial infarction was without question considered to be totally and permanently disabled. Fortunately for the insurance companies, and still more for the patient, this is no longer true.

A fairly common manifestation of peripheral vascular disease in older patients, especially men, is intermittent claudication, which may cause so much pain in the calf muscles after the patient walks a variable distance that he is forced to stop and rest. I have found in treating this condition that it is essential for the patient to stop smoking altogether, but he may be partly compensated for this deprivation by being allowed to take an ounce or two of whisky or brandy three times a day, since alcohol is one of the best vasodilators available. Priscoline or a xanthine derivative, such as aminophylline, may be substituted.

Hypertension. Even in old people, the psychic element may play a large part in hypertension. Every experienced physician knows that the usual level of a patient's blood pressure can not be determined by a single reading. I quite agree with Dr. Paul White that "Overemphasis on hypertension . . . has resulted in a great deal of unnecessary apprehension, and this very apprehension . . . increases the blood pressure at the time of the examination."¹⁰

In examining a patient for the first time, I rarely take the pressure until I have first talked to him long enough to feel that he is at ease. It is good practice to take the reading in both arms before recording it. If the examiner's reaction to the first reading is reassuring, the second will almost invariably be lower. I have seen a patient's blood pressure vary by as much as 40 mm. of mercury at a single office visit.

A frequent finding in older patients is a systolic murmur, usually heard best along the left sternal border. Monroe¹¹ comments that "one soon becomes accustomed to hearing (such a) murmur in the great majority. It may vary greatly under the influence of tachycardia, pain, excitement, fever, or any illness." He suggests that it is useful to have a record of the behavior of the murmur when the patient is in his usual health, since its change indicates some sort of

disorder and its return to normal indicates recovery.

The Respiratory System

Chronic bronchitis is probably the most frequent disease of the respiratory tract in older people. Bronchiectasis and emphysema are also common. Asthma may occur, but when it begins in later life, it is usually on the basis of cardiac failure. The possibility of pulmonary tumor is also to be kept in mind. Tuberculosis has been discussed earlier, under "infections."

The Gastrointestinal Tract

Peptic ulcer occurs more frequently in men, gallbladder disease in women—especially mothers. Ulcer usually begins in younger life, but may persist into old age. Exacerbations and such complications as hemorrhage and perforation often follow emotional stress in the older as well as the younger patient. The treatment of ulcer and its complications and of gallbladder disease follows virtually the same principles in both age groups.

Diverticula of the bowel, especially of the colon, are comparatively common in older patients. Except for the occasional case of diverticulitis — "left sided appendicitis" — which demands close watching and may require surgery, I agree with Monroe that for diverticula "No treatment at all is best, but it is hard to give."¹²

Diaphragmatic hernia occurs more often in older people, and may follow a prolonged cough. Patients with this condition should be advised not to overload the stomach with bulky meals, and are sometimes made more comfortable by the use of some antispasmodic.

It should be remembered that acute appendicitis does occur in old people, and is apt to have an insidious onset, with less pain, less nausea, less fever and a lower leukocyte count than in younger patients.

Pancreatitis is more common in older people, and is, I believe, often on a vascular basis. Of

about 100 cases that my colleagues and I have seen within the past nine years, more than 60 per cent were in patients 40 or older; 20 per cent of the patients were 60 or more years of age. Pancreatitis should always be kept in mind as a possible explanation of sudden severe upper abdominal pain, and a serum amylase determination should be made at the time of the attack.

A malignant lesion of the stomach or bowel should, of course, be ruled out in a patient with vague digestive complaints, change in bowel habits, and blood in the stools. The prognosis in cancer of the colon, if it is found early and removed surgically, is remarkably favorable.

Various observers have demonstrated that the hydrochloric acid secreted by the stomach decreases with age, and that many old people have a complete achlorhydria. In some cases this causes surprisingly little digestive disturbance. Other patients who are deficient in hydrochloric acid may have a considerable amount of gas and bloating after meals. Sometimes a persistent diarrhea can be relieved quickly by dilute hydrochloric acid in doses of $\frac{1}{2}$ to 1 teaspoonful with each meal. From one of my patients I learned that tomato juice is the best carrier for the acid, which makes an excellent tomato juice cocktail. A stubborn hypochromic anemia is often overcome when hydrochloric acid is given with iron.

Constipation. Some wit has said that the three ages of man are as follows: (1) when he boasts of the pretty girl he dated the night before; (2) when he recalls the good dinner he ate last night; and (3) when he tells of the good bowel movement he had this morning. Thanks largely to the advertising profession, a large proportion of the American public has a really morbid fear of constipation. I have had the idea that the constipation bogey was most prevalent in the older age group, but Monroe¹³ thinks that all ages are alike its victims. I have seldom tried to interfere with the laxative habit in people past 60, but Monroe has made me reconsider this stand by citing the case of a

retired school teacher 92 years old whom he persuaded to abandon the habit, and who "has written me several letters expressing her annoyance at having the convictions of 90 years exploded." I, too, have had the gratifying experience of receiving, from patients whom I had persuaded to do without laxatives, a few letters that compare favorably with the most glowing testimonials given any patent medicine manufacturer.

Whether or not one can succeed in persuading an oldster to give up his favorite purgative, at least one can remind him of Hippocrates' injunction: "Use purgative medicines . . . not without proper circumspection."

Especially to be condemned is the regular use of mineral oil by mouth. At the 1941 meeting of the American Medical Association, a whole session of the Section on Gastroenterology was devoted to a panel discussion of drug therapy in the gastrointestinal tract, in which mineral oil came in for particular condemnation.¹⁴ Since then the late Dr. C. A. Anderson, a general practitioner in North Carolina, learned to use it as a rectal injection at bedtime, in order to have "the skids greased" for a movement next morning.¹⁵ I have found this method to be effective in many patients, especially those with fissure or painful hemorrhoids.

A balanced diet is equally important in adults of all age groups. Old people are apt to eat too much carbohydrate food at the expense of proteins and green vegetables, with the consequent development of obesity and vitamin deficiencies. The best single piece of advice that could be given most individuals past 40 is to restrict their diet so as to hold their weight down to the optimum figure. It is not a bad idea to give vitamin concentrates to older patients—especially to those who feel that they must take some medication—as a supplement to their diet.

So far as I know, there is no valid reason to forbid older patients the use of coffee and tea. Tobacco in moderation, unless there is a tendency to claudication or Buerger's disease, need

not be prohibited. As regards alcohol, one may recall the dictum of the late Dr. Lewellys Barker that a man is a fool if he drinks whisky before he is 40 and a bigger fool if he doesn't drink after 50. As in other habits, however, moderation is to be advised; and alcohol should, of course, be strictly forbidden for any person who has ever been addicted to its use.

The Genitourinary System

In a recent analysis of 1251 autopsies performed on patients past 50, Medalia and White^{7b} found that 460 had arteriosclerotic nephritis (nephrosclerosis), and 105 had pyelonephritis. From the therapeutic standpoint, however, pyelonephritis is perhaps the most important form of nephritis. When used in its early stages, the new urinary antiseptics now available are often successful in curing a disease which, if neglected, runs a relentlessly progressive course. It is important, of course, to determine by urine culture the organism or organisms present and, in stubborn cases, to perform sensitivity tests in order to evaluate its susceptibility to the various drugs which might be employed. It is important also to recognize and remove, if possible, renal calculi, tumors, and any other abnormalities in the urinary tract which may interfere with proper drainage.

Prostatism in old men is usually recognized easily. Osler's famous dictum, "Never overlook the rectum," is too often forgotten, however, with the tragic result that cancer of the prostate is often far advanced before it is discovered. In older women symptoms similar to those of prostatism may be produced by chronic inflammation of the vesical neck. The resultant hypertrophy of the muscles at the bladder neck often causes difficulty in voiding—a condition which may be relieved by a transurethral resection as effectively as is prostatism in men.

Cystoceles are frequent in old women, and their repair may give great comfort. A pelvic examination should be done routinely on every older woman who is or has been married, and

on single women if there is any indication. I have been impressed by the number of cervical polyps thus found. Often they are symptomless, but they are almost certain to cause bleeding sooner or later; the danger of malignant degeneration is also present, and for this reason they should be removed and examined by a competent pathologist.

The Bones and Joints

Although in most instances the distinction between rheumatoid, infectious, or atrophic arthritis and hypertrophic, degenerative or osteoarthritis is easily made, the two conditions are too often confused. True rheumatoid arthritis which may cripple its victim nearly always begins before the age of 40, while the hypertrophic type is seldom evident before 50. Rheumatoid arthritis is more apt to affect the smaller joints, especially those of the hand, while hypertrophic arthritis affects the larger, weight-bearing joints—the lumbosacral joints, the hips, and the knees. The single exception is the curious tendency of hypertrophic arthritis to select the distal joints of the fingers of women, forming the well known Heberden's nodes. It has been said that these hurt a woman's vanity more than anything else.

As a rule, hypertrophic arthritis does not require any special treatment beyond reassurance to the patient that the condition almost never proves disabling; it is merely a mechanical condition resulting from the wear and tear of years, and is analogous to the wearing of the moving parts of an automobile. If the patient is overweight, he should be advised to reduce gradually to his optimum level in order to relieve some of the strain on the joints.

Osteoarthritis of the spine with spur formation is often overlooked as a cause of pain in the intercostal nerves. This type of pain, which is due to pressure from a spur, has a curious tendency to come and go—perhaps because unusual or prolonged exertion with some trauma to the dorsal nerve root may cause temporary

edema. In some cases injection of the nerve or even resection of the offending nerve roots is necessary to give relief.

The thoracolumbar syndrome of Jacobs¹⁶ may be responsible for pain in the lower back, the lower abdominal quadrants, or the gluteal region. Dramatic relief may be obtained by injecting Novocain into the nerve root supplying the painful area.

Bursitis, especially of the subacromial bursa, seems to be increasing in frequency. We have found x-ray therapy helpful in most cases. Another condition to be mentioned in passing is the shoulder-hand syndrome, or reflex muscular dystrophy, which may occur after a myocardial infarction, pulmonary infarction, cerebral vascular accident, or any of a number of other conditions which may give rise to reflex irritation of the brachial plexus through the so-called internuncial pool.

The possibility of gout as an explanation for a suddenly swollen, painful joint in an older man should always be kept in mind. Ninety-five per cent of the victims of this disease are men, though the most classic case of podagra I ever saw was in a woman. Joints other than the great toe may be affected. The distal joints are most vulnerable, and the spine is almost never involved. An elevated serum uric acid level and a dramatic response to colchicine confirm the diagnosis.

The Endocrine System

The thyroid. Hypothyroidism is not unusual at any age, and is often overlooked as a cause of persistent fatigue and occasionally of a stubborn anemia. Kimble and Stieglitz have published an excellent discussion of this condition in *Geriatrics*.¹⁷ It should be suspected in any patient who complains of constant fatigue, is sensitive to cold, and has dry hair and skin.

The opposite condition, hyperthyroidism, is more common in women, and may be the masked or "apathetic" type. I recall an elderly woman whose chief complaint was rapid and irregular

heart action with evidences of congestive failure. Digitalis had no effect on the heart rate or rhythm. She was so cold-natured that she kept a blanket over her in July—but a slightly enlarged thyroid and a fine tremor gave the clue to her difficulty. Lugol's solution brought her pulse rate down to normal, and a thyroidectomy made the cure permanent.

Parenthetically, we have found the most reliable objective index of thyroid activity to be the amount of protein-bound iodine in the serum. The normal range is 4 to 8 micrograms per hundred cubic centimeters.

The gonads. Symptoms of the climacteric appear much more commonly in women than in men, and are much more amenable to hormone substitution therapy. In our experience, the two most common mistakes made in giving estrogens to women are (1) beginning their use too soon, and (2) failing to recognize menopausal symptoms occurring years after the actual cessation of the menses. I make it a rule never to give an estrogenic substance before menstruation has actually stopped, to use small doses, and to give the drug in cycles. To be specific, I prescribe the synthetic preparation, stilbestrol, in enteric-coated tablets of $\frac{1}{4}$ mg., to be taken daily after the evening meal for three weeks, then omitted for a week. After two or three such cycles, I ask the patient to reduce the dosage schedule to four or five times a week, then to three times, and gradually to omit the drug altogether.

Seldom have I found it necessary to prescribe androgens for men. Perhaps the fact that a North Carolina Civil War veteran married a young woman and begat two children when he was 94 and 96 years old has helped strengthen my sales resistance.

It is not necessary to dwell on the beneficial effect of estrogens in men with osseous metastases of prostatic cancer, or on the value of androgens in women with metastases from cancer of the breast.

The Skin

The only suggestion I have to offer as an amateur dermatologist is that the dry, itching condition of the skin which is common in old people is often relieved dramatically by large doses of vitamin A—100,000 units daily at first, and later 50,000 units. Cold cream or skin lotions used locally also help to prevent dryness and chapping.

PSYCHOLOGICAL ADJUSTMENTS TO AGE

One of the most important functions of the family doctor in dealing with older patients is to help them to make the necessary psychological adjustments. Many of the most unpleasant traits of adolescence and old age alike arise from a feeling of being useless and unwanted. Stuart Chase, in *The Road We Are Traveling*, gave the key to this problem when he said: "Men want to *belong*; to feel that they are a part of a living community, that they have a place in it which other people recognize." Although it is not within the scope of this paper to deal with the economic factors involved in the custom of requiring workers to retire at a given age, regardless of their mental and physical fitness, the medical man has a real interest in this problem. It is not surprising that a man who is forced to retire from his lifelong occupation while he is still vigorous and alert frequently becomes the victim of a mental depression.

The steadily increasing proportion of older people in the population means that the custom of retirement at a fixed age entails a tremendous waste of manpower. The Sun Life Insurance Company has estimated that by 1970, if the present trend continues, as many of the adult population will be on pension as at work. This statement means that every worker will have to support a non-worker, directly or indirectly. It is significant that in the First National Conference on Aging, held in Washington in August, 1950, eight of the eleven sections went on record as favoring a change in the present policy of forcing workers out of employment at a fixed

age, regardless of their ability to continue at work.

Another problem which doctors are often asked to help solve is that of caring for older widowed or dependent relatives. Occasionally the presence of a parent or grandparent in the home may be a real benediction, but only too often the opposite is true. Whenever feasible, it is usually best for all concerned for older dependents to live apart from the families of their children or grandchildren—either in their own home, apartment or room, or in one of the homes for older people which are becoming recognized as a necessity in our modern society. If it is actually necessary to take an old person into the home, it is best to have a distinct understanding at the very beginning that he or she is not to be a petty tyrant. Neither should he be made to feel helpless by too much attention and “bossing,” but should be allowed to do for himself as much as he is able. As long as he can get about, it is well to assign him some task in order to make him feel that he is useful.

In his task of helping his older patients to make a sound psychological adjustment, the doctor has the invaluable assistance of Nature, which has beneficently arranged it so that one's viewpoint changes with advancing years. Except at the climacteric, adjustments to increasing age levels are made so gradually as to be almost imperceptible.

A. C. Benson, in his charming essay “On Growing Older,”¹⁸ gives four advantages of maturity:

1. “The loss of . . . self-consciousness.”
2. The decreasing tyranny of convention.
“I discovered gradually that to adopt the principle of doing disagreeable things which were supposed to be amusing and agreeable was to misunderstand the whole situation. . . . I am not at the mercy of small prejudices, as I used to be.”
3. “I do not think that life is so rapturous, but it certainly is vastly more interesting.”
4. “Then, too, the greatest gain of all, there

comes a sort of patience. . . . One learns to look over troubles, instead of looking into them; one learns that hope is more unconquerable than grief.”

A few suggestions for mental adjustment to age are offered for consideration by our older patients—and incidentally by ourselves.

1. Recognize that the mind should be at its best at 40, and should continue to be efficient to the age of 70 or more. The pathologists have shown that organic changes in the brain do not necessarily parallel mental changes. If properly trained, the mind does not lose its elasticity, and constant use of the brain helps keep it efficient. Stieglitz has expressed the consoling thought that wisdom depends upon experience, in which time is a factor.

2. Avoid becoming an “old fogey” by associating occasionally with young people. Prepare for occasional shocks, but try to understand their viewpoint.

3. Learn to delegate authority and to unload responsibility upon younger shoulders. There is an advantage in partnerships in which the enthusiasm of youth is balanced by the judgment of maturity.

4. Cultivate wide interests. Learn new uses for the hands and brain, and exchange more strenuous amusements for others less exciting. To quote A. C. Benson¹⁸ again, “One ought to grow older in a tranquil and appropriate way . . . to be perfectly contented with one's time of life . . . amusements and pursuits ought to alter naturally and easily, and not be regretfully abandoned.”

5. Keep in touch with old friends and make new ones. Dr. Samuel Johnson once said, “If a man does not make new acquaintances as he advances through life, he will soon find himself alone. A man, sir, should keep his friendship in a constant repair.”

6. Cultivate equanimity—“the mental poise that keeps one from being unduly elated by good fortune or depressed by bad news, and that teaches one to take fortune's buffets and

rewards with equal thanks.”¹⁹ This statement does not mean that one should become indifferent or lose enthusiasm, which has been defined as the motive power of progress. It is important to keep a proper balance between emotion, which furnishes the driving power for the human machine, and reason, which corresponds to the steering gear and the brakes. I know of no better way to acquire this balance than to adopt Osler’s “Way of Life”²⁰—learning to live “in day-tight compartments.”

7. Finally, cultivate the habit of looking forward rather than backward. This advice may seem to conflict with Osler’s admonition to live one day at a time, but it really does not. Planning for tomorrow is often part of today’s task—but sighing over yesterday accomplishes nothing. The greatest bore in all literature must have been Coleridge’s “Ancient Mariner,” who with his skinny hand kept a wedding guest away from the wedding feast while he told an interminable tale of a shipwreck suffered in his youth. Even though it be difficult, one should always be ready to exchange outmoded ideas for new and better ones.

Two philosophers who lived centuries apart have expressed my own feeling about adjustments to age far better than I could. More than two thousand years ago, Plato wrote: “Old age has a great sense of calm and freedom; when the passions relax their hold, then . . . we are freed not of one mad master only, but of many. . . . He who is of a calm and happy nature will hardly feel the pressure of age, but to him who is of an opposite disposition youth and age are equally a burden.”

The other philosopher is Dr. Francis M. Pottenger, who in the final chapter of his autobiography said: “My 80 years do not worry me. . . . To be sure, I would like again to have the keenness of youth. On the other hand, I would miss the mellowness of age, the store of experience which guides me in my every movement

and act. I have tried not to live too much in the past, but to be alert to the problems of the future. This I have accepted as an antidote to aging. It does not prevent the years from rolling by . . . , but it does prevent that fear of the future which otherwise might make one unhappy in the twilight of life.”²¹

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CHOLECYSTOGRAPHY USING TELEPAQUE*

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Many attempts have been made since the introduction of iodoaliphonic acid to discover some radiopaque dye that will make gallbladders more easily visualized with heavier concentrations of the dye. Ideally, a gallbladder contrast medium should have the following properties: (a) specificity for the gallbladder; (b) contain a radiopaque element; (c) be promptly absorbed by the intestinal tract; (d) be eliminated in the bile and stored in the gallbladder; (e) produce little or no systemic toxic symptoms; (f) have little or no side effects; (g) be easily administered; (h) be readily excreted.

A compound that closely approaches possessing all these properties is a new organic iodine-containing compound—TELEPAQUE.† This product studied in the experimental animal by the Research Department of Winthrop-Stearns Corporation has the chemical nomenclature of 3-(3-amino-2,4,6 triiodophenyl)-2-ethylpropionic acid. The chemical formula is $C_{11}H_{12}I_3NO_2$. Its molecular weight is 571.0. It contains 66.68% iodine as compared with a maximum of 51.38% iodine content of previous compounds. It is a cream-colored solid that is insoluble in water and soluble in dilute alkali and 95% alcohol as well as other organic solvents.

Conclusions reached in laboratory research in the experimental animal were: 1) The average densities of the gallbladder after Telepaque were approximately the same as those for iodoaliphonic acid in cats at equal dose levels, and more dense with Telepaque in the dogs when dose level was taken into account; 2) By oral administration in mice, Telepaque is less than one-third

as toxic as iodoaliphonic acid; 3) By tests employed there was no evidence of kidney and liver insufficiency following repeated doses of 500 and 1,000 mgm. per kilogram of Telepaque administered orally to dogs. It is with these points in mind, e.g., excellent visualization of the gallbladder, low toxicity and absence of any renal or hepatic insufficiency, that we undertook a study of this new product in order to evaluate its merits as a cholecystographic medium.

In this preliminary study, twenty-nine consecutive cases were given Telepaque regardless of age, sex, weight or suspected pathology. Routinely, the patients were instructed to take one tablet every five minutes, beginning at 11 P.M., the night before the X-ray examination. The reason for advocating ingestion of Telepaque at this hour is that maximum concentration of the dye is obtained in 10 to 12 hours. The total number of tablets to be given was based on the patient's weight. All patients below 165 lbs. were given six Telepaque tablets (3 grams), whereas all above 165 lbs. were given nine tablets (4.5 grams), but no more than nine tablets were given to any one patient.

A preliminary film of the gallbladder region was obtained on the day the patient came to make an appointment. The patients reported for roentgenologic examination the following morning at 9:00 A.M. One 8 x 10 PA film and one 8 x 10 right oblique film (prone position) of the gallbladder region were taken. However, one 14 x 17 PA view of the abdomen, supine, which is our routine with other dyes, was also taken to observe the amount of dye remaining in the intestinal tract and that had not been absorbed. Our usual routine does not include an upright film. Patients were asked whether the

* From the Department of Radiology, University Hospital, Baltimore, Md.

† Winthrop-Stearns, Inc., 170 Varick Street, New York 13, N. Y.

ingested tablets had caused any nausea, vomiting, heart-burn, burning on urination or diarrhea either the same night following the ingestion of the tablets or the morning following. A gastrointestinal series followed the study of the gallbladder according to our routine in this hospital. The latter studies, however, do not enter into this present evaluation of Telepaque. One week following the initial gallbladder series, another gallbladder study was performed but this time with our usual gallbladder dye, iodoalphonic acid. Fatty meals to study contraction of gall-

type were visualized clearly with Telepaque and very poorly with iodoalphonic acid. Whether coincidental or not, it is to be observed that those patients weighing up to 150 lbs. (except in one case) had gallbladders that concentrated both dyes to the same intensity. It is with heavier patients that a greater difference in density of the two dyes is present. A very interesting observation that startled us on initial inspection of our films is that "excellent" concentrations were obtained with heavier patients. This, we believe, is due to the larger percentage of iodine in the compound itself.

Schemata for Evaluating Concentration of Dye

VISUALIZATION INDEX	DESCRIPTION
3	EXCELLENT....A sharp outline of the gallbladder that stands out in sharp contrast with surrounding tissues.
2	GOOD.....A distinct shadow of the gallbladder with satisfactory intensity and good definition.
1	FAIR OR POOR...A faint shadow of the gallbladder or faint evidence of gallbladder without definition. This usually implies impaired function.
0	NEGATIVE.....No evidence of the gallbladder concentrating the dye.

FIGURE 1

bladder, etc., is not a routine procedure at this clinic.

Figure 2 summarizes the results of our observations. The scoring scheme for the interpretation of the cholecystograms is demonstrated in Figure 1. The average visualization index for Telepaque tablets in our initial series of 29 cases, is 2.2 as compared to a visualization index of 1.69 for iodoalphonic acid. Two patients complained of moderate nausea in the first series and nausea was encountered once in the second series. No patient in either series had more than one soft bowel movement the morning following ingestion of Telepaque. It is important to note that in one case, gallstones of the radiolucent

Series I

PATIENTS	WEIGHT	VISUALIZATION INDEX (MEAN AVERAGE)		RESULTS*
		Telepaque	Iodoalphonic Acid	
29	89-240	2.24	1.69	Cholelithiasis... 1 Normal..... 28

Series II

20	102-237	2.10	1.85	Cholelithiasis†... 1 Normal..... 19
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* Four duodenal ulcers were demonstrated.

† Associated pathology demonstrated: duodenal ulcer—5, spastic colon—1, renal tumor—1.

FIGURE 2

In our second series of twenty cases, we administered only six Telepaque tablets (3 grams) to each patient, regardless of body weight. The results appear to be similar to those of our first series, that is, a slightly better concentration than with iodoalphonic acid. Apparently, similar concentrations can be obtained in non-diseased gallbladders with different dyes. It is interesting to observe that in one case in this series no concentration of Telepaque could be seen, whereas there was a slight concentration visible with iodoalphonic acid.

The fact that a "good" concentration could be obtained in a normally functioning gallbladder in one case—body weight, 237 lbs.—indicates that perhaps the over-all dosage of this

new drug may be comparatively less than for other preparations. In a future series of cases, patients will be selected from the "heavier" weight group in an attempt to assay a quantitative dosage per body weight. The most striking case showed excellent concentration after taking six Telepaque tablets. (Fig. 3). Note the numer-

with different dyes. It is possible, as has been mentioned in one of our cases, to demonstrate a gallbladder non-functioning with too few tablets and then to show very good concentrating function with a larger amount of the same type of dye. It is an interesting fact that a review of all our cases revealed all the patient's gallbladders



FIG. 3. Cholecystogram of case No. 34, after six Telepaque tablets, showing good concentration of the dye and also demonstrating numerous faceted non-opaque calculi. This gallbladder was not demonstrated with six iodoalphonic acid tablets. A second examination with nine iodoalphonic acid tablets showed good visualization of the gallbladder but the calculi could not be seen.

ous small faceted stones. No visualization of the gallbladder was noted after the ingestion of six iodoalphonic acid tablets. A third gallbladder series, after the administration of nine iodoalphonic acid tablets, showed good concentration of the dye but the multiple faceted stones were not seen. The authors believe that the present-day procedure of administering dye according to the patient's weight can give variable results

to concentrate Telepaque at least "good." None in our series could be classified as "poor" concentration or "no" concentration.

CONCLUSIONS

1. Our small preliminary series leads us to believe that Telepaque is a slightly better contrast dye for gallbladder concentrations than previously marketed dyes, particularly in patients weighing over 150 lbs.

2. Side reactions are less noted than with previously used dyes. Only an occasional complaint of nausea was received, whereas this was a rather frequent complaint with the control dye. No true diarrhea was encountered in any of our patients.

3. There appears to be less variation in the concentration of the Telepaque as compared to the control dye.

4. It is believed that good concentrations can be obtained in heavy patients with a standardized average dose of Telepaque.

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HILL-BURTON HOSPITAL CONSTRUCTION PROGRAM SLOWING DOWN

Capitol Clinic, A.M.A., Vol. 3, No. 44, November 4, 1952

During six years, the Hill-Burton Hospital Construction program has approved 1,877 projects for federal grants totaling just over *half a billion dollars*. Of the 90,645 beds, about 44% already are in operation, the remainder under construction or in planning stages.

The latest progress report, as of September 30, also shows that inflation and budget restrictions are rapidly slowing down the program. In fiscal 1950 a total of 537 projects were completed or on the books; the total for the current fiscal year is not expected to exceed 150.

For fiscal 1948 and 1949, the first full years of operation, appropriations were \$75 million annually. In 1950, Congress increased the maximum limit to \$150 million, and voted the full amount. Appropriations for the subsequent three years were \$85 million, \$82.5 million and \$75 million. Meanwhile, construction costs per bed increased, according to hospital authorities, about 50%.

The program was designed particularly to build small hospitals and in rural areas, but from the start a high percentage of the funds has gone to relatively large institutions in urban areas. On this the analysis supplied by Division of Hospital Facilities, Public Health Service, states: "Although 57% of the new projects are for facilities with fewer than 50 beds, *only 25% of the federal funds . . . (go) . . . to these smaller facilities*. A little more than half of the federal money for new hospitals assists facilities with 100 or more beds. For additions or alterations, 82% of federal funds is going to hospitals with 100 beds or more." With emphasis on larger, long-range jobs (19 medical school-connected hospitals on current list), reduced grants are not immediately reflected in the administrative workload, which is expected to continue at about its present level for several years.

Under the law, funds are allocated to states for distribution. Determination of what projects to assist is the responsibility of the state hospital authority, based on a survey of hospital facilities and willingness of local communities to make plans and raise money.

Health Department

BALTIMORE CITY HEALTH DEPARTMENT

New Toxoid Program and Greeting Card

On November 1st the City Health Department inaugurated in the city's well baby clinics a changed inoculation schedule for the combined diphtheria and tetanus toxoid with whooping cough vaccine. Clinic infants are now given a half cubic centimeter dose of the triple antigen at monthly intervals; the first at four months of age, the second at five months and the third at six months of age. Similar booster inoculations will follow at eighteen months of age and again when the child first enters school. The change in part is to give an earlier protection against whooping cough.

Simultaneously with this change a new Greeting Card is being sent to each Baltimore baby (thirty to fifty a day) to arrive on the day he is four months old, to urge that the family physician give toxoid for the prevention of diphtheria. The Greeting Card is a revision of the Six Months Greeting Card which has been used by the City Health Department for almost twenty years. The text of the card, except for the above change, is practically the same as it was previously and the wording is as follows:-

FOUR MONTHS OLD TODAY!

GREETINGS FROM YOUR CITY HEALTH DEPARTMENT

Dear Little Baby,

Congratulations! Four Months Old Today.

We, the Mayor of Baltimore, and your Commissioner of Health, send you our greetings on this im-

portant milestone in your life and wish you the best of health.

Now that you are four months old, we have a message of special importance for you and your parents. We know that your Mother and Father want to keep you well and strong. They want you to have health and happiness. They want to protect you from disease:

At your age, one of your ugliest and most cruel enemies is DIPHTHERIA. You are young and helpless. You cannot protect yourself against this dreadful enemy, but your Mother and Father can safely protect you by means of TOXOID. This protective treatment is advised by the Medical Societies of Baltimore. The best age to get this protection is as soon as possible after you are four months old.

WE HOPE YOUR PARENTS WILL PLAN NOW TO PROTECT YOU AGAINST DIPHTHERIA.

Surely, if you could talk you would ask them to do this for you. Maybe the next time you cry, your Mother or Father will understand that you are begging for their help and will take you to a physician who will give you these safe and harmless toxoid inoculations, or refer you to one of the Health Department clinics.

With best wishes for your health and happiness,

Thomas D'Alesandro, Jr., **Huntington Williams, M.D.,**
Mayor *Commissioner of Health*

City physicians who may wish to discuss these matters may do so by calling Dr. Janet Hardy, Director of the Bureau of Child Hygiene, at Plaza 2000, Extension 324.

VOLUNTEERS NEEDED!

Mrs. R. Walter Graham, Jr., Chairman of Womans' Division of The American Cancer Society, Maryland Division, asks Auxiliary members to volunteer for the April Cancer drive. Please telephone Mrs. Graham, Belmont 8269.

STATE OF MARYLAND DEPARTMENT OF HEALTH
MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, October 31–November 27, 1952

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCAL	MUMPS	POLIOMYELITIS, PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYPHOID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORRHEA	OTHER DISEASES	DEATHS Influenza and pneumonia
Total, 4 weeks																		
Local areas																		
Baltimore County.....	32	—	1	3	2	—	1	1	—	11	—	—	7	19	—	16	—	2
Anne Arundel.....	2	—	2	—	—	—	1	—	—	2	—	—	2	4	1	—	—	3
Howard.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	2
Harford.....	14	1	—	2	2	1	—	1	—	—	—	—	—	—	—	1	m-2	2
Carroll.....	1	—	—	—	—	—	—	—	—	—	—	—	—	1	1	1	—	2
Frederick.....	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	1	—	—
Washington.....	9	8	—	—	—	—	1	—	—	1	1	—	—	8	—	2	—	1
Allegany.....	2	—	—	—	—	—	—	—	—	—	—	—	—	4	—	—	—	3
Garrett.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Montgomery.....	16	—	—	—	1	—	7	4	—	—	—	—	—	12	—	1	—	1
Pr. George's.....	19	—	—	—	—	—	6	1	—	3	—	—	1	13	—	—	—	4
Calvert.....	—	—	—	1	—	—	—	1	—	—	—	—	—	—	1	—	—	—
Charles.....	5	—	—	1	—	—	—	—	—	—	—	—	—	1	—	1	—	2
Saint Mary's.....	—	—	—	7	—	1	—	—	—	—	—	—	—	—	—	—	—	—
Cecil.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2
Kent.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Queen Anne's.....	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—
Caroline.....	1	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1	—	—
Talbot.....	—	—	—	—	—	—	1	—	—	—	—	—	—	2	—	—	—	—
Dorchester.....	—	—	—	—	—	—	1	—	—	1	—	—	—	6	—	1	—	—
Wicomico.....	4	—	—	—	2	—	—	—	—	—	—	—	1	4	1	14	—	1
Worcester.....	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Somerset.....	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	2	—	—
Total Counties.....	105	9	3	14	7	2	18	9	0	18	1	0	11	79	6	43		25
Baltimore City.....	86	0	3	8	19	1	39	1	0	47	0	0	7	91	4	520		11
State																		
Oct. 31–Nov. 27, 1952.....	191	9	6	22	26	3	57	10	0	65	1	0	18	170	10	563		36
Same period 1951.....	141	2	10	29	634	3	56	12	0	63	4	10	36	186	26	540		68
5-year median.....	149	9	5	—	34	6	57	18	0	65	4	2	127	185	84	577		46
Cumulative totals																		
State																		
Year 1952 to date.....	2981	17	848	229	9126	80	1014	184	29	967	21	15	195	2474	178	7946		588
Same period 1951.....	2889	37	864	230	6334	52	3677	79	43	854	21	35	427	2506	303	6922		484
5-year median.....	3242	173	393	—	2970	108	1303	151	56	1001	35	39	1246	2534	1179	7082		608

m = malaria reported by Aberdeen Proving Grounds, contracted outside the U. S. A., residence not stated.

Component Medical Societies

ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

Journal Representative

The October meeting of the Allegany-Garrett County Medical Society was held on October 24, in the auditorium of the Memorial Hospital nurses' home.

The speaker for the evening was Dr. W. Royce Hodges, local Obstetrician and Gynecologist and his paper was titled, "Ten Years Experience with Obstetrical Pain Relief." Dr. Hodges addressed the Twenty Sixth Annual Congress of Anesthetists in London, England, just one year ago.

The following articles appeared in the *Cumberland Evening Times*:

DOCTOR NAMED TO HEALTH JOB

Dr. Winter R. Frantz, city and county health officer, announced yesterday that Dr. Ralph A. Reiter, 743 Fayette Street, has accepted a position as pediatric consultant of the State Department of Health.

Assigned to part-time duty with the Allegany County Health Department, Dr. Reiter's work will deal mostly with the school health program of the department.

The appointment, Dr. Frantz added, will enable the Health Department to provide examinations for students engaged in competitive sports. Dr. Reiter will also have charge of the immunization program in the schools.

Dr. Reiter opened an office here in August to practice pediatrics.

A son of Mr. and Mrs. George F. Reiter, 801 Memorial Avenue, he was graduated from Fort Hill High School in 1940. After completing medical studies at the University of Maryland he entered the Navy, serving in the Palau Islands and on Guam.

Following his discharge, he served as resident physician at Memorial Hospital in 1949 and then went to the Mayo Clinic, where he completed a three-year course in pediatrics this year.

Dr. Frantz said Dr. Reiter is eligible to take the test for election to the American Board of Pediatrics.

SYMPOSIUM ON THE MEDICAL AND SOCIAL ASPECTS OF THE ADOPTION LAW OF THE STATE OF MARYLAND UNDER CHAPTER 63 OF THE ACTS OF 1950—MEDICAL AND LEGAL ASPECTS IN ARTIFICIAL INSEMINATION AND STERILITY

Osler Hall, 1211 Cathedral Street, Baltimore

Friday, February 6, 1953, 8:00 p.m.

(Speakers to be announced.)

THE MEMBERS OF THE MEDICAL AND CHIRURGICAL FACULTY ARE URGED to attend this meeting. The Symposium is under the auspices of the Joint Committee on Medicolegal Problems of the Baltimore City and Maryland Bar Associations and the Medical and Chirurgical Faculty. The program is being arranged by the Symposia Management Subcommittee which is composed of the following members: Mr. S. C. Berenholtz, Mr. W. L. Galvin, Mr. A. Sodaro, Mr. T. C. Waters, Dr. R. S. Fisher, Dr. L. Krause, Dr. R. C. Tilghman, and Dr. I. R. Trimble.

All these meetings will be held at 1211 Cathedral Street unless otherwise stated.

BALTIMORE CITY MEDICAL SOCIETY

Osler Hall

Friday, January 16, 1953, 8:30 p.m.

PANEL DISCUSSION: BLOOD DYSCRASIAS

Cyrus C. Sturgis, M.D., *Moderator*

Professor of Internal Medicine, University of Michigan School of Medicine,
Ann Arbor, Michigan

Participants

Medicine. C. Lockard Conley, M.D.

Radiology. Robert N. Cooley, M.D.

Medicine. Vernon H. Norwood, M.D.

Medicine. Milton S. Sacks, M.D.

SECTION ON DISEASES OF THE CHEST

MOSES S. SHILING, M.D., *Chairman*

EDMUND G. BEACHAM, M.D., *Secretary*

Wednesday, January 7, 1953, 8:00 P.M.

Speaker and subject to be announced.

OTOLARYNGOLOGICAL SECTION

J. JULIAN CHISOLM, M.D., *Chairman*

C. CARLETON DOUGLASS, M.D., *Secretary*

Tuesday, January 13, 1953, 6:00 P.M.

Dinner Meeting, Johns Hopkins Club, Homewood

The program will be a talk by an outstanding Maryland figure in medicine. Full arrangements had not been completed at the time this Journal went to press.

PEDIATRIC SECTION

JOHN A. ASKIN, M.D., *Chairman*

JOSEPH M. CORDI, M.D., *Secretary*

Tuesday, January 13, 1953, 8:30 P.M.

Jaundice in Infancy. David Hsia, M.D., The Children's Medical Center, Boston, Massachusetts. (By invitation.)

Discussion. Victor A. Najjar, M.D., Harriet Lane Home, Johns Hopkins Hospital.

BALTIMORE COUNTY MEDICAL SOCIETY

DONALD L. SOMERVILLE, M.D.

Journal Representative

At a recent meeting of the Baltimore County Medical Society, held at the Penn Hotel in Towson, the following new members were voted on and accepted: Active membership—Earl W. Harris, Jr., Robert Todd Hyde, J. Everett Sanner; Associate membership—Walter K. Spelsberg, Raymond N. Cunningham; Dentists—Donald H. Hobbs, Emmett P. Dagon, John T. Stang, Irving G. Katz. Guests at this meeting were Dr. Harold H. Weinberg and the new director of Eudowood Sanatorium, Dr. R. Shirrell Rogers.

We were all privileged to hear an address by Dr. Frank Figge, Professor of Anatomy at the University of Maryland Medical School. The subject was the "Organizer Concept," in which the speaker brought out the fundamental interdependence and intercommunication among all bodily cells, a breakdown of which is possibly related to the etiology of new growths. His theory was magnificently illustrated by motion pictures, made with the help of the phase microscope, showing unstained, living cells actually dividing—some normally, some (from malignancies) bizarrely. There is, according to Dr. Figge's concept, a "primary organizer," the nature of which is probably chemical, causing the integration and differentiation of the embryo, and indeed continuing all through life—as exemplified by the control the hypothysis holds over our bodily chemistry and physiology through its many hormones. This fundamental principle leads many investigators to the conclusion that carcinomata are engendered through a breakdown in the normal "intercommunications," through a hormonal mechanism.

In October the Society met at the Stafford Hotel, where considerable business came up for consideration. We heard the report of a recent executive committee meeting, containing several controversial items that have been hot potatoes in our hands for many years; chiefly, of course, this applies to the problem of time and place of meetings, and a certain amount of experimentation is to be undertaken involving Sunday afternoon as a time, and a more central location—such as the Medical and Chirurgical Faculty Building—as a place. It was voted to increase the

financial help for the Secretary of the Society for next year, in order for him to be better able to hire stenographic help for the large amount of paper work involved in the Society's activities. The matter of central storage of the Society's records, now apparently scattered in several localities, was settled by voting to look into the possibility of using the space now held by us at the Medical and Chirurgical Faculty for all records. The motion to incorporate the Society was duly considered and passed.

The scientific portion of this meeting was conducted delightfully and educationally by Dr. Harry M. Robinson, Jr., who gave us all a much greater insight than before into the problem of Contact Dermatitis; apparently if we live long enough we will see everything imaginable along this line, for Dr. Robinson showed and discussed the case of a young lady who was distressingly and incurably allergic to money.

PRINCE GEORGE'S COUNTY MEDICAL SOCIETY

SAMUEL J. N. SUGAR, M.D.

Journal Representative

Mr. Theodore Wiprud, secretary of the District of Columbia Medical Society, gave a very interesting talk at the October meeting on Medical Economics.

Dr. Wolcott Etienne addressed the Berwyn Heights P. T. A. on October 21, 1952. His subject was "Health of Your Child."

The annual Dinner Dance of the Society was held November 15, 1952 at the Shoreham Hotel. Members and guests enjoyed the festivities.

Election of officers for 1953 will be held the first Tuesday in December.

WASHINGTON COUNTY MEDICAL SOCIETY

W. D. CAMPBELL, M.D.

Journal Representative

The Annual Meeting of the Washington County Hospital Staff was held September 26, 1952. The following officers were elected:

Dr. Ernest F. Poole, President

Dr. Phillip J. Hirshman, Vice President

Dr. Archie I. Cohen, Secretary and Treasurer

Library

OUR NEW LIBRARIAN

MISS HELEN WHEELER

The new Librarian of the Medical and Chirurgical Faculty, Miss Helen Wheeler, assumed her position on November 1, 1952. The Association is fortunate to have her on the Staff.

Miss Wheeler is known to many of our members as she was Head of the Reading Room and Circulation Department at the Welch Medical Library of the Johns Hopkins University, and for the past five years was Medical Librarian at the Sinai Hospital. Miss Wheeler was graduated from Western High School in Baltimore and received her A.B. degree at Goucher College. In 1945 she received her B.S. degree from the School of Library Service, Columbia University. She has done social work in both Baltimore and South Carolina, and did secretarial work for doctors for ten years. She has studied in France, and has received diplomas or certificates from the Sorbonne, the Alliance Francaise and the University of Clermont. Miss Wheeler is the author of "A Check List of Rush's Writings in the Welch Medical Library," *Bull. Hist. Med.* 19: 107-112, January 1946.

Miss Pauline Duffield, who served as Librarian from July 1946 until November 1952, has accepted the position of Librarian at the Texas Medical Association in Austin, Texas. Miss Frieda Hewes and Mrs. Bettie McQuay have tendered their resignations and taken positions respectively with Dr. Nicholson J. Eastman and Dr. Otto C. Brantigan. The Medical and Chirurgical Faculty expresses appreciation to these former Library employees and wishes them success in their new positions.

Mrs. Eleanor Kohler will continue in her present capacity in the Library and assist Miss Wheeler. The members of this Association look forward to the future with Miss Wheeler and Mrs. Kohler to carry on the work of the Library of the Medical and Chirurgical Faculty.

THE BARKER FUND

Lewellys Franklin Barker was born in Milldale, Oxford County, Ontario, Canada, on September 16, 1867. He died in Baltimore on July 13, 1943. As a member of the Medical and Chirurgical Faculty, he served on the Council and on the Library Centennial Celebration Committee. In 1925, he held the position of President of the Faculty.

After Dr. Barker had received the thorough preparatory schooling of his day, he wanted to continue his education but his father's income was not sufficient and it was necessary for him to work. While serving as an apprentice to a druggist, he became interested in the study of medicine. In order to obtain this aim, he had to support himself with scholarships and money earned during summer vacations. In 1890, he received the degree of Bachelor of Medicine from the University of Toronto, winning its highest honors for scholarship.

While serving as an intern at the Toronto General Hospital, he decided to continue his career at Johns Hopkins Hospital in Baltimore. Securing an appointment, he came to that hospital. Since the fellowship did not carry a salary, Dr. Barker found it necessary to write editorials for Dr. George M. Gould, of Philadelphia, who paid liberally for the work.

For the following nine years, he was engaged in research work in anatomy under Dr. Franklin P. Mall and in pathology under Dr. William H. Welch. Since the staff of the hospital was composed of many famous men, Dr. Barker had the opportunity to work with them in the shaping of modern medicine.

In 1895, he spent six months in Leipzig doing research work under Dr. Max von Frey, who was carrying out a research project on the localization of the sensory points in the skin. As part of the project, Dr. Barker made a study of sensibility, using his own arm for the experiment. With the encouragement of Dr. Mall, he wrote an account of the histology of the cerebrospinal and sympathetic nerv-

ous systems and of their motor, sensory and association paths. Thus, he entered the field of modern neurological histology in America. This was a field of description in which he was a pioneer. Although he had written a number of books in his lifetime, he considered this first work of greater scientific value than any of the others.

Upon the recommendation of Dr. Mall in 1900, he was appointed Professor of Anatomy at the University of Chicago, where he remained for the next five years. While in Chicago, he translated and edited Spalteholz's "Hand Atlas of Human Anatomy."

During this period, he accepted an invitation to address the Johns Hopkins Alumni in the West. This occasion presented the opportunity to express his ideas on the "whole-time" professors in the clinical chairs of the university medical schools. He made a plea for better organization and endowment of the medical departments of the universities; a plea to pay professors a living wage and not force them to depend on a private practice. This idea, which Dr. Barker in his autobiography credits to Dr. Mall, became a controversial question.

In 1905, Dr. William Osler, Professor of Medicine and Physician-in-Chief of the Johns Hopkins University School of Medicine, vacated the Chair of Medicine, which Dr. Barker was elected to fill. His work had been chiefly devoted to anatomy and pathology until this time; but, upon returning to Baltimore, he soon became proficient in clinical medicine and in the techniques employed in diagnosis and treatment. Realizing the importance of investigation, the work in the clinical laboratories was extended and several small laboratories were provided for additional work in the fields of biological, biochemical and physiological methods in medicine. These laboratories were in the charge of young physicians, who were given a small salary so that they might be able to carry out their investigations without the distraction of private practice.

In 1913, it became possible for the Hopkins Medical School to reorganize the departments along the lines advocated in Dr. Barker's speech of "whole-time" professors. Dr. Barker was offered the opportunity to head the Department of Medicine under this new plan but he felt that he had to decline the offer. Instead, he accepted the Professorship of Clinical Medicine, which he held the remaining years of his life.

Dr. Barker was a member of many important societies, a frequent contributor to medical literature and the recipient of honorary degrees from the universities of Toronto, McGill, Glasgow and Queens.

In 1916, with the assistance of Dr. Maurice C. Pincoffs, he published a three-volume work on "The Clinical Diagnosis of Internal Diseases;" and, in 1922, he edited a five-volume work on "Endocrinology and Metabolism." During his last years, he wrote a fascinating story of his life, entitled "Time and The Physician."

Under the will of Dr. Barker, the Library of the Medical and Chirurgical Faculty was left the sum of one thousand dollars for the purchase of books and journals.

The Faculty bookplate is used and the Barker Fund is so designated.

THE HERBERT HARLAN MEMORIAL FUND

On behalf of the professional friends of Dr. Herbert Harlan, the former Governor Phillips Lee Goldsborough of Maryland presented a portrait of Dr. Harlan and the Herbert Harlan Memorial Fund to the Faculty at the annual meeting on April 22, 1924. The contributors to the Fund specified that the income from the Fund was to be used by the Library Committee to purchase books, monographs and journals on the subject of ophthalmology and that this material was to be marked "Purchased by the Herbert Harlan Memorial Fund."

Herbert Harlan was born at Churchville, Harford County, Maryland, on May 7, 1856. His father, Dr. David Harlan, was a Medical Director for the United States Navy. Consequently, young Harlan obtained his education wherever his father was stationed. He received his early schooling in Harford County and in Philadelphia, where his father was assigned during the War between the States. While his father was the Surgeon-in-Charge at the United States Naval Academy, the son attended the Preparatory Department of St. John's College; and, later, a parish school connected with Holy Trinity Church, near Churchville. He then went to St. Clement's Hall in Ellicott City, Maryland.

In 1873, he entered St. John's College at Annapolis and was graduated with an A.B. degree in 1877. In the fall of 1877, he entered the Medical School of the University of Maryland and was graduated in

1879. After a year of additional medical study in Europe, he returned to Baltimore and began his practice.

His first experience in practice was as Clinical Assistant in Neurology to Dr. Francis T. Miles. At the same time, he began his work in ophthalmology at the Presbyterian Eye, Ear and Throat Charity Hospital under Dr. Julian J. Chisolm. Dr. Harlan was associated with this hospital from the beginning to the end of his professional life: first, as an Assistant Surgeon, from 1880-1890; then, as Surgeon; and, later, serving more than ten years as the Surgeon-in-Chief. In addition to the many years in which Dr. Harlan was associated with the Presbyterian Eye, Ear and Throat Charity Hospital, he was affiliated with the staffs of other institutions. In 1880, he began a ten-year service with the University of Maryland as a teacher, when he became an Assistant Demonstrator, and later the Demonstrator, of Anatomy. From 1890 to 1893, he was Professor of Diseases of the Eye and Ear at Baltimore University; and, from 1896 to 1902, he was connected with the Women's Medical College at Baltimore.

Dr. Harlan joined the Medical and Chirurgical Faculty in 1881 and was President of the Faculty from January 1, 1923, until his death on August 16,

1923. He was elected to the State Board of Medical Examiners in 1904; and, from 1906 until his death, he served as President of that Board.

Dr. Harlan was aware of the medical needs of the State and took an active part in their solution. In 1894, he worked for the enactment of the law requiring the reporting of cases of ophthalmia neonatorum. In 1897, he organized and conducted the examination of the eyes of the public school children in Baltimore. During his Presidency of the State Board of Medical Examiners, laws were enacted and enforced to prevent incompetent men from entering the profession and to curtail the activities of illegal practitioners. In 1915, a resumé of his work for the Public Health Bureau of the United States on the cause of trachoma in the mountain counties of Kentucky was published in the *Maryland Medical Journal*. This publication was one of the many outstanding contributions that Dr. Harlan made to the field of medical literature.

REFERENCES

- CROUCH, J. F., FRIEDENWALD, HARRY, AND WOODS, HIRAM, Herbert Harlan Memorial Fund Report, Tr. Med. Chir. Fac. Maryland **126**: 80, 1924
WOODS, HIRAM, Herbert Harlan, Tr. Am. Ophth. Soc. **22**: 16-19, 1924

RANDOLPH WINSLOW, M.D.

1852-1937

Dr. Randolph Winslow was a member of the Medical and Chirurgical Faculty, having joined in 1876, and was active until his death. He served on the Council, and many committees. He was President in 1914.

Dr. Winslow's granddaughter, Mrs. A. Waldo Jones of Atlanta, Georgia, paid tribute to her grandfather on his 100th birthday on October 23, 1952 by having flowers placed beneath Dr. Winslow's portrait, which hangs in Osler Hall in the Faculty Building.

This Association wishes to express its appreciation to Mrs. Jones. The Medical and Chirurgical Faculty honors the memory of one of its esteemed members—Dr. Randolph Winslow.

BLUE CROSS AND BLUE SHIELD

WHY MORE THAN 1,600 MARYLAND PHYSICIANS SUPPORT BLUE SHIELD

R. H. DABNEY, *Executive Director**

1. The Blue Shield Plan has medical sponsorship.

Only Blue Shield is sponsored by the physicians of Maryland through the Medical and Chirurgical Faculty and its component county societies.

2. Any licensed physician may become a Participating Physician of Blue Shield.

Any licensed physician in the State of Maryland may request participating membership at any time. More doctors are added each month to the growing list of Blue Shield Participating Physicians.

3. The Service Feature.

The great advantage of Blue Shield over other forms of coverage is the Service Feature.

This feature, which has been discussed at length in previous issues of the Journal, is the physician's solution to the problem of providing prepaid care for their patients in the lower income brackets.

4. Blue Shield offers free choice by the patient.

Patients have free choice—they may continue with their family physician as Blue Shield benefits are payable to any licensed physician. Patients are not limited to a small group of doctors.

Of course, doctors also have free choice; they are not bound to treat a patient simply because he is a Blue Shield member.

5. Non-profit operation.

The income that Blue Shield receives from subscription charges is used to pay for the care received by members, the cost of administration, and to maintain a reasonable reserve for contingencies as required by state law. There are no stockholders, no dividends, and no commissions paid to its sales representatives.

* Maryland Hospital Service, Inc. and Maryland Medical Service, Inc.

6. A minimum of "red tape."

The physician reports his services on a simplified, single, one-copy form that is provided by the Plan. As soon as the report of services has been received and approved by the Plan, a check is mailed to the physician.

7. Flexibility for unusual or complicated cases.

When a case seems worthy of special consideration as to payment, the physician should include an explanation of the case on his report of services to the Plan. The case is then reviewed by the administrative officers and the physician is notified of the amount payable. The physician always has the right of appeal to the Reference and Appeals Committee on such cases.

8. Blue Shield is "the Doctor's Plan."

The twelve-man Board of Trustees of Blue Shield includes eight physicians appointed by the Faculty. Since the activities of the Plan are inextricably bound up with the physicians' interests, the doctors' representation on the Board enables them to exercise a majority vote on the determination of such issues as the professional policies of the Plan and the amounts listed on the Schedule of Benefits. It is in every way "the Doctor's Plan."

9. The growth of Blue Shield.

The growth of Blue Shield in Maryland during its first year of operation is a significant indication of the confidence placed in it by the public. This confidence is founded in the knowledge that Blue Shield is "the Doctor's Plan"—a knowledge that any plan sponsored by the doctors in the community will give to the public the best medical and surgical care at the lowest possible cost.

Woman's Auxiliary to the Medical and Chirurgical Faculty

MRS. GEORGE H. YEAGER, *Auxiliary Editor*

GENERAL MEETING

MEDICAL AND CHIRURGICAL FACULTY,
ANNUAL MEETING*

Wednesday Night, April 30, 1952

DR. ALAN M. CHESNEY, *President, Presiding.*

Dr. Chesney: I think it must be obvious to the most careful observer that this is Ladies Night. This is that portion of the program in which we do honor to the distaff side, the Woman's Auxiliary of the Faculty, and thank them for all the help which they have given the Faculty during the past year.

I note from the program that this is the third Annual Meeting of the Woman's Auxiliary. I must say for three years that organization has been going strong. It is perfectly obvious to me that there hasn't been any feeding problem as far as that organization is concerned and I trust no temper tantrums.

I am particularly happy to be able to thank the Woman's Auxiliary this evening because of the great assistance which they gave to the Medical Schools and the Medical Society for medical research nearly two years ago, on the occasion of the Dog Bill, the referendum before the City Council to amend the Charter in such a way as to really prohibit animal experimentation, in this city. I am quite familiar with what they did during that campaign. They did a marvelous job.

I wonder sometimes whether we would have won had it not been for the help which the ladies particularly of the Auxiliary of the Baltimore City Society gave us. The fact is I'm reminded of a story in that connection, a story on Mark Twain which I have been recently assured is authentic because it is published in Albert Bigelow Payne's "Life of Mark Twain." The story deals with the early period of Mark Twain's career when he came to Washington as a newspaper correspondent, at that time relatively unknown. He soon acquired quite a reputation as an after dinner speaker and was in consider-

able demand for banquets. Those were the days when it was always customary to have a series of toasts after the banquet was over, and on this particular occasion Mark Twain was called upon to respond to the toast to the ladies. He gave a very flowery oration and ended up with an oratorical question which ran as follows: "... in fact what would we be if it were not for the ladies? I'll tell you, Mr. Toastmaster, we would be scarce, we would be scarce." It is entirely possible that we would not have had a victory without the ladies two years ago.

I have the pleasant duty of presenting to the Faculty the present President of the State Woman's Auxiliary. I do this with a certain amount of sadness because when you have known an individual since they were knee-high and then come to the point where you introduce them as the President of an organization, it makes you feel very old indeed.

I must say that if association with doctors is any qualification for the presidency of the Woman's Auxiliary to the Faculty, certainly Mrs. Yeager fulfills those qualifications. I am sure that most of you know that she is the daughter of a surgeon, she is the sister of a surgeon and she is the wife of a surgeon. She has a little boy who she tells me expects to study medicine. I only hope that he will elect when he gets his M.D., to be a medical man and redress the balance in the faculty. I'm sure that you will all agree that any one medical man is equal to any three surgeon.

Without further ado I shall present to you Mrs. Dorothy Stone Yeager, President of the Woman's Auxiliary of the Faculty.

REMARKS OF MRS. GEORGE H. YEAGER, *President*

Mrs. George Yeager: I really only want to thank very much the Medical and Chirurgical Faculty for these lovely flowers which I appreciate very much. I would like to thank Dr. Chatard for representing the Faculty and receiving the Governor's Proclamation of Doctors Day for us, and I would like to thank the staff of the Faculty whom I shall miss.

* The first part of the meeting, Transactions, 1952.

like my right arm. They have kept me from making some of the blunders that I would have made every day. In fact I'm in rather an intimidated state right now about saying anything because at lunch today I turned out to be an unintentional wit. I don't think I'll ever live it down.

I just want to say to the doctors that we have a little Public Educational Program in the Auxiliary, in which we try to do some good work for the doctors; for medicine; for medical research; Civil Defense Nurse Recruitment; Americanism; and we recently have tried to testify in favor of fluoridation of Baltimore City's drinking water. We are working on a lot of medical problems. We would like to have every doctor's wife a member. I would like to thank Mrs. Compton for that wonderful Art Show upstairs, and I'd like to say that I'm really not the President, Mrs. Charles H. Williams is today the new President but I guess she will talk to you next year.

WHAT ABOUT OUR AMERICAN EDUCATION?

MRS. A. S. CHALFANT, *Chairman**

The historian, Lord Acton, once said that, "Liberty is the delicate fruit of a mature civilization." We Americans know that we have inherited the greatest amount of Liberty ever enjoyed by any people. What we may not have realized is that this Liberty was the priceless living element in our society which enabled us to conquer a continent and become a great nation; that it is the real and dynamic reason why we have succeeded in developing a standard of living for the common man unequalled anywhere else in the world; that it is the reason why our Medical men, unfettered, have been able to excel in knowledge and in service with the result that we Americans are better cared for medically than any other people.

It is most essential therefore that we understand this fact,—it is possible that we can lose this element so necessary to the physically and spiritually abundant life of our people. Our Forefathers gained it, not easily, but through determined struggle, and if we are to retain it we will have to struggle even as they did for it is seriously threatened.

We have seen the light of Liberty extinguished in

many countries since the end of World War II. We are learning that what has happened there can happen here also. It will happen here unless we, as citizens, bestir ourselves to prevent it.

We are all conscious of the very present danger to our country in the world situation, but most of us have been unmindful of *the dangers here at home*. The Founders of our country warned us that the most serious threat to our liberties would arise, not from abroad, but *from within*. How can we recognize these internal dangers? We learn from history that a too great concentration of power always leads to a tyranny and the destruction of what we fondly call "inalienable rights." In their struggle for Liberty through the centuries Americans have always fought power-hungry Big Government. Because we have been free, in America for so long, it is hard to convince ourselves that there is any threat to our freedom now! Where would it come from, in what guise would it appear?

The very basis of our free society lies in the wise provision of the men who wrote our Constitution, whereby the power of the state was divided among the three separate branches of our government,—Executive, Legislative, and Judicial, so that no one man or small group of men, could have too much power over us. This basis of our liberties is threatened today, for unfortunately, there are those among us who have ceased to love Liberty as our Fathers did and as the vast majority of us still do. These people have fallen prey to alien ideas and philosophies and have forgotten, or are no longer loyal to, these basic principles on which our country was founded and upon which our liberties depend. They, foolishly, have no fear of an all-powerful state and continually advocate measures which would give to the Executive more and more power. They urge increasing Federal control of every phase of our private lives, and they would take from the States and give to the Federal government those powers which are specifically and carefully allotted to the States by the Constitution. The boldest of them refer to the Constitution as "an outworn instrument" not suited for our present age. How and where do these people work? Who can tell us about them? How strong are they?

The Patriotic Societies, The American Legion, and similar groups, have done some interesting research on the means and methods by which these

* Committee Chairman American Education.

people seek to influence us for their own purposes. There are certain brave men in Congress who have risked and suffered much to tell us what they have found out. There are groups of embattled citizens such as the Small Businessmen's Association which publishes "The Educational Reviewer," who try to inform us about what is going on under our unsuspecting noses. The consensus of opinion of these loyal, earnest, citizens has been that there is a deliberate attempt on the part of a well organized minority to manipulate our educational system so as to condition the minds of our children for what they call "a new social order." Every Auxiliary member should read, "Your Child is their Target," by Irene Corbally Kuhn, in the June 1952 issue of the American Legion Magazine. Here is a quotation from the Congressional Record of Saturday, October 20, 1951, when this matter was discussed,— "Remember, they do not teach Communism. They do not teach Socialism as such. The scheme is first to *break down the child's faith in our form of government* and then to sell him a half dozen ideas which, when all put together, mean socialism." (Emphasis ours)

How strong are these people? We believe they are not numerically so very strong, but they are very vocal, and having easy access to the press they make noisy and concerted attacks on any who have the temerity to call attention to their evil doings. In consequence they exercise an influence out of all proportion to their number and they succeed quite often in silencing the timorous or smearing the courageous. For an example see the article in "McCall's Magazine," which attempts to discredit Mrs. Lucille Cardin Crain for her excellent work in combatting the teaching of collectivism in our American schools. Edgar Hoover, of the F.B.I. has told us of the concentration of subversives on the East and West Coasts of our country,—that there are many such in New York City. This makes the recent accounts in "The New York Times" of the battle to rid the New York School System of Communist teachers exceedingly interesting reading. In the "Times" of October 23, 1952, there is an account, by Murray Illson, of eight teachers having been suspended since January 31st, on charges of "insubordination and unbecoming conduct" because they refused to answer questions dealing with al-

leged Communist party membership. The courts had previously upheld the Superintendent's right to ask such questions of them. Mr. Moskoff, Assistant Corporation Council, quoted the following from an article in the May 1937 issue of "The Communist," a magazine on party theory published in the United States:

"Only when teachers have really mastered Marxism Leninism will they be able skilfully to inject it into their teaching *at the least risk of exposure* and at the same time to conduct struggles around the schools in a truly Bolshevik manner." (Emphasis ours)

The only thing honest citizens determined to preserve for their children the birthright of liberty which has been bequeathed, can do is to get into the battle in such numbers and with such enthusiasm and dedication that the victory here at home will be assured. We must make it our business to know what our children are being taught, and if we do not like it, we must tell our friends and neighbors. Together, with each helping the other, we shall destroy "the enemy within the gates."

GETTING OUT THE VOTE

MRS. THOMAS C. WEBSTER, *Chairman*†

The Woman's Auxiliary to the Medical and Surgical Faculty, as its contribution to the Ballot Battalions' work of getting out the vote provided baby sitting services for voting parents on November fourth; drove people to the polls, and made thousands of phone calls to ensure as large a vote as possible.

In Baltimore County Mrs. M. E. Strobel, President of the County Auxiliary, and Mrs. Charles H. Williams, State Auxiliary President, worked in Cooperation with the County doctors and many cooperating Ballot Battalion organizations.

In the City The Woman's Auxiliary to the Baltimore City Medical Society established thirty baby sitting centers, to take care of every ward and with *several* in the larger more attenuated ones. We secured doctors' offices, churches, and recreation halls for this use. Ministers, priests, and rabbis were glad to cooperate with us on this non-partisan effort. The response that we got from everyone was most encouraging and made one proud to be an American and to live in a Country where groups having di-

† Chairman Legislation.

vergent views can work so well together for the good of all.

Auxiliary members staffed the child care centers from nine until four o'clock assisted sometimes by church members or members of the other cooperating organizations of the Ballot Battalion. The Auto-

presidents gave many hours and made many calls to get out the vote in the Counties.

AUXILIARY NEWS

Mrs. Beverley C. Compton, Chairman of the Creative Arts Show, which will be held at the time of the



A SUMMER BOARD MEETING

WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

Front Row, left to right:

Mrs. H. Hanford Hopkins, Mrs. H. Melvin Radman, Mrs. Albert E. Goldstein, Mrs. Homer Todd, Mrs. George H. Yeager, Mrs. Arthur York, Mrs. A. S. Chalfant.

Back Row, left to right:

Mrs. Edwin H. Stewart, Jr., Mrs. E. Ellsworth Cook, Mrs. Julius Holly, Mrs. Richard Coblenz, Mrs. Harry Bowie, and Mrs. Thomas Webster.

motive Association not only drove people to the polls, but saw that the children were transported to and from our baby stations. After four o'clock the children of voting parents were cared for by the Girl Scouts of The Baltimore Area.

Mrs. Albert E. Goldstein, our City President, did a great part of the work in securing places to keep the children and generally assisted in this project just as our hardworking State and County

Annual Meeting, urges Auxiliary members to start now to encourage their husbands to exhibit. She would like to have more work from the doctors themselves this year, although doctors' wives and children will of course participate as always.

A recent issue of the "News Letter" of the Maryland State Planning Commission notes under "Briefs" that The Woman's Auxiliary to the Medical and Chirurgical Faculty "has passed a resolution

urging closer medical supervision of mentally or physically impaired drivers."

Mrs. Harry Davies reports that The Woman's Auxiliary to the Montgomery County Medical Society made a great success of their Health Booth at their four day State Fair. Their attendance totaled five thousand persons on the first day alone, and a film about farm accidents, narrated by a physician, which was shown by them proved very popular. Mrs. Davies was especially delighted at the great number of Auxiliary volunteers and at their en-

thusiasm for the project. She pointed out too, that the A.M.A. literature chosen for distribution included some of a general nature and some dealing specifically with rural problems.

Bad weather combined with illness made things difficult for Mrs. Gerald LeVan and the Washington County Auxiliary members who staffed their Health Booth at the Hagerstown State Fair. However, plans were followed through successfully, and a nurse in uniform was present to assist with their Nurse Recruitment drive.

EISENHOWER AND TAFT AGREE ON COMMISSION TO STUDY HEALTH, WELFARE PROBLEMS

A.M.A. Capitol Clinic, Vol. 3, No. 47, November 25, 1952

President-Elect Eisenhower and Senator Taft, the dominant Republican in the Senate, have agreed that *a commission should be set up to study all federal-state relations in the field of aids and grants, including health and welfare problems*. If the idea receives Congressional approval, it probably will mean "freezing" health and welfare programs at their present level for the next year while the commission carries on its investigation. Some commission members would be appointed by the new President, the remainder by House and Senate leaders. Senator Taft said he expected it to be "predominantly" Republican.

Senator Taft discussed the suggestion following his meeting in New York with the General, where all major legislative issues were taken up. Although he said everything still was in the "thinking out" state, the Senator emphasized *the General was in agreement with him that the commission method appeared the best approach to the problem*. During the campaign Gen. Eisenhower had said he favored an extension of social security. "If we set up the commission, we will hold what we have in these fields but we probably won't enact any legislation that costs more money," the Senator said, "because there's no money left to spend until we can reduce heavy military costs."

DOCTOR DRAFT DEBATED DURING 3-DAY MEETING OF ASSOCIATION OF MILITARY SURGEONS

A.M.A. Capitol Clinic, Vol. 3, No. 47, November 25, 1952

The doctor draft and its future were the dominant theme of the Washington meeting of the Association of Military Surgeons. But left unanswered were two important questions: 1. Just how much time do military doctors spend on care of dependents? 2. Can sufficient personnel be obtained for the services on a voluntary basis? The law expires June 31 unless extended by Congress.

Ancillary News

NURSING SECTION

M. RUTH MOUBRAY, R.N., *Administrator*

Steering Committee, Joint Board of Directors of the Three Maryland State Nursing Organizations

BETTER EDUCATION NEEDED FOR NURSES*

New priorities must be given education for nursing if our health program is to keep pace with improvements in plants and equipment, states Elizabeth Ogg in a provocative new study of current nursing needs, *PREFARING TOMORROW'S NURSES*, recently published by the Public Affairs Committee, New York City, in cooperation with the National League for Nursing.

In spite of wide American interest in public health, the preparation of nurses—our largest group of health workers—has been acutely neglected. This is chiefly due to the fact that the nursing profession has outgrown its former role. As Ruth Sleeper, President of the National League for Nursing, points out: "The scope of nursing has broadened immeasurably in recent years, and advances in medical science have added new duties and new responsibilities. The preparation of tomorrow's nurses is as much a matter of public concern as the construction of a much-needed hospital."

Today the modern nurse, if she functions effectively, is the doctor's co-worker. Besides her traditional nursing abilities she must know something of psychology and be expert in many scientific techniques that once were considered purely the doctor's province. Frequently too she must have administrative abilities.

Not only must nurses be well prepared, but there must be many more of them. The 335,000 registered nurses on active service are not nearly enough to go around. Hospitals are forced to put up with poorly trained personnel many times because they can't find better. Solution to the problem must go back to the

nursing schools—which must receive more support from the general public to do their job.

The burden of nursing training has fallen too heavily on hospitals, which support most of our nursing schools, Miss Ogg points out. Although half the expense of all other forms of higher education is borne by the public, not so with nursing: here only 7 per cent comes from public sources.

The only way to ease the heavy budget burden for hospitals is to have the student "pay her way" with services to patients, which she does to a large extent in most hospital schools. All too frequently the valuable time of a student nurse is taken up with repetitive chores that neither increase her knowledge nor improve her efficiency. Consequently as a graduate nurse she is unable to be as effective as she might otherwise be. Ideally her hospital and other experiences should be planned as learning. A student nurse has so much to learn that everything she does should be geared to it.

The appeal of the nursing profession has grown greatly in recent years, as nurses have moved out into the fields of industrial nursing, public health administration and education.

Practical nurses and auxiliaries give roughly half the medical care in our 6,000-odd hospitals today, Miss Ogg points out. Nursing teams of professional nurses, practical nurses, and auxiliaries make it possible for hospitals to spread available professional nursepower farther.

The organizations that combined to form the National League for Nursing have already done much to improve nursing standards and focus public attention on nursing needs. Frank to admit the weaknesses in current nursing education, it is vigorously tackling ways to close the gap between the kind of care we get and the kind we need and want.

* National League for Nursing, 2 Park Avenue, New York 16, New York.

But, as the NLN says, better nursing is everybody's business. The public must help achieve it.

Copies of the pamphlet may be ordered for 25

cents each from the National League for Nursing, 2 Park Avenue, New York 16, New York. Discounts on quantities will be quoted on request.

PHARMACY SECTION

Maryland Board of Pharmacy

L. M. KANTNER, PHAR.D., *Secretary*

COOPERATION ESSENTIAL

With the passage of the Durham-Humphrey Bill, amending the Federal Food, Drug, and Cosmetic Act, it was generally agreed by those familiarizing themselves with the provisions of the new law that inconsistencies existing in drug distribution would largely be corrected.

Unfortunately, all is not working as well as anticipated. This Law permits pharmacists to accept prescriptions (except for narcotics) by telephone, as well as to accept orders by telephone from physicians to refill prescriptions.

Reports are being received to the effect that patients are complaining about the delay in receiving prescriptions presented to a pharmacy for *refilling*. Pharmacists are giving the reason for such delays that they call a physician to obtain his authorization to refill a prescription and find the physician is out. In such cases, a request is left to have the physician call the pharmacist—to obtain his authorization to refill a prescription—such requests are often ignored, and call after call has to be made in order to communicate with the physician and before the pharmacist is permitted to refill and deliver the prescription.

It is well known that many physicians are working to the limit of their physical endurance, and the telephone is a source of much annoyance—this holds for all who have dealings with the public. As an example, the writer just recently kept an accurate account of the time consumed on incoming phone calls for one day, and exactly two hours and seven minutes was so consumed.

It must be realized that pharmacists are held to strict compliance with the provisions of the recently enacted law, relative to dispensing legend drugs only

on prescriptions, and the refilling of same requires the physician's authorization. Authorization can be included in the original prescription and if this is not done, then it must be obtained orally from the physician.

What likely is not recognized by some practitioners is that a *patient* cannot, under any circumstances, convey the physician's order to refill a prescription for a legend drug—provision, however, has been made to allow his nurse or secretary to convey from the physician an order to the pharmacist to refill the prescription.

After the debating on the Durham-Humphrey Bill in Congress and its final passage, Mr. Oscar R. Ewing, Administrator Federal Security Agency, came out with the statement that it was his opinion it should have been a requirement on the part of the physician to include in the prescription whether or not he authorized its refilling.

It has to be recognized that in many cases, the physician when prescribing a drug is unable to foresee the need of continued use, and in such cases, he certainly would not authorize the refilling on the original prescription.

The class of effective medication in use today is a type that necessitates medical supervision in its administration. It is for this reason a stringent Federal Law was enacted controlling the dispensing of such drugs.

Too much medication is likely comparable to too little medication. It was for this purpose, the use of certain types of drugs was restricted to physicians.

Therefore, again suggestion is made to the physician to include in his prescription:

N. R.....
Refill.....
Refill P. R. N. till.....

DIRECTORY*

MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

March 31, 1951–March 31, 1952

LIST OF PRESIDENTS—1799–1952

- | | | |
|-----------------------------------|----------------------------------|------------------------------------|
| 1799–1801—Upton Scott. | 1887–1888—I. Edmondson Atkinson. | 1923—Herbert Harlan (Jan.–Aug.). |
| 1801–1815—Philip Thomas. | 1888–1889—John Morris. | Harry Friedenwald (Aug.–Dec.). |
| 1815–1820—Ennals Martin. | 1889–1890—Aaron Friedenwald. | 1924—Philip Briscoe. |
| 1820–1826—Robert Moore. | 1890–1891—Thomas A. Ashby. | 1925—Lewellys F. Barker. |
| 1826–1836—Robert Goldsborough. | 1891–1892—William H. Welch. | 1926—Thomas B. Johnson, Deceased |
| 1836–1841—Maxwell McDowell. | 1892–1893—L. McLane Tiffany. | December 25, 1925. |
| 1841–1848—Joel Hopkins. | 1893–1894—George H. Rohé. | 1926—Josiah S. Bowen. |
| 1848–1849—Richard Sprigg Steuart. | 1894–1895—Robert W. Johnson. | 1927—Thomas S. Cullen. |
| 1849–1850—Peregrine Wroth. | 1895—J. Edwin Michael. | 1928—Peregrine Wroth, Jr. |
| 1850–1851—Richard Sprigg Steuart. | 1895–1896—Charles G. Hill. | 1929—Alexius McGlannan. |
| 1851–1852—William W. Handy. | 1896–1897—William Osler. | 1930—Henry M. Fitzhugh. |
| 1852–1853—Michael S. Baer. | 1897–1898—Charles M. Ellis. | 1931—J. M. H. Rowland. |
| 1853–1854—John L. Yeates. | 1898–1899—Samuel C. Chew. | 1932—Eldridge E. Wolff. |
| 1854–1855—John Fonerden. | 1899–1900—Clotworthy Birnie. | 1933—J. Albert Chatard. |
| 1855–1856—Jacob S. Baer. | 1900–1901—Samuel Theobald. | 1934—George O. Sharrett. |
| 1856–1857—Christopher C. Cox. | 1901–1902—J. McPherson Scott. | 1935—J. M. T. Finney, Sr. |
| 1857–1858—Joshua I. Cohen. | 1902–1903—William T. Howard. | 1936—Frederick D. Chapplear. |
| 1858–1859—Joel Hopkins. | 1903–1904—Eugene F. Cordell. | 1937—Arthur M. Shipley. |
| 1859–1870—Geo. C. M. Roberts. | 1904–1905—Edward N. Brush. | 1938—Frank B. Hines. |
| 1870—John R. W. Dunbar. | 1905–1906—Samuel T. Earle, Jr. | 1939—Dean Lewis: Acting President, |
| 1870–1872—Nathan R. Smith. | 1906–1907—Hiram Woods. | Victor F. Cullen. |
| 1872–1873—P. C. Williams. | 1907–1908—Charles O'Donovan. | 1940—Edward P. Thomas. |
| 1873–1874—Charles H. Ohr. | 1908–1909—Brice W. Goldsborough. | 1941—Harvey B. Stone. |
| 1874–1875—Henry M. Wilson. | 1909–1910—G. Milton Linthicum. | 1942—R. Lee Hall. |
| 1875–1876—John F. Monmonier. | 1910–1911—Franklin B. Smith. | 1943—Charles R. Austrian. |
| 1876–1877—Christopher Johnston. | 1912—Hugh H. Young. | 1944—Jacob W. Bird. |
| 1877–1878—Abram B. Arnold. | 1913—Archibald C. Harrison. | 1945—Carroll Lockard. |
| 1878–1879—Samuel P. Smith. | 1914—Randolph Winslow. | 1946—Thomas R. Chambers. |
| 1879–1880—Samuel C. Chew. | 1915—J. W. Humrichouse. | 1947—William T. Hammond. |
| 1880–1881—H. P. C. Wilson. | 1916—J. Whitridge Williams. | 1948—Charles W. Maxson. |
| 1881–1882—Frank Donaldson. | 1917—Guy Steele. | 1949—W. Houston Toulson. |
| 1882–1883—William M. Kemp. | 1918—William S. Halsted. | 1950—A. Austin Pearre. |
| 1883–1884—Richard McSherry. | 1919—John Ruhräh. | 1951—Walter Dent Wise. |
| 1884–1885—Thomas S. Latimer. | 1920—James E. Deets. | 1952—Alan M. Chesney. |
| 1885–1886—John R. Quinan. | 1921—William S. Gardner. | |
| 1886–1887—George W. Miltenberger. | 1922—Arthur H. Hawkins. | |

LIST OF VICE-PRESIDENTS

- | | | |
|-------------------------------------|-----------------------------------|----------------------------------|
| 1799–1848—(Unknown.) | 1855–1856—George C. M. Roberts, | 1859–1863—John R. W. Dunbar, |
| 1848–1849—John Readell, Jacob Baer, | G. W. Miltenberger, M. Diffen- | Samuel Chew, Wm. M. Kemp. |
| P. Wroth. | derffer. | 1863–1871—John R. W. Dunbar, |
| 1850–1851—Joel Hopkins, P. Wroth, | 1856–1857—P. Wroth, Wm. H. Davis, | Wm. M. Kemp, John C. Hopkins. |
| Jacob Fisher. | Samuel Smith. | 1871–1872—C. H. Ohr, Edward War- |
| 1851–1853—(Unknown.) | 1857–1858—William Waters, Fred- | ren, Richard McSherry. |
| 1853–1854—John Fonerden, Albert | erick Dorsey, Joel Hopkins. | 1872–1873—(Unknown.) |
| Ritchie, P. Wroth. | 1858–1859—Samuel Chew, Stephen | 1873–1874—Samuel Chew, H. M. |
| 1854–1855—Geo. C. M. Roberts, | N. C. White, Samuel K. Handy. | Wilson, A. B. Arnold. |
| Samuel P. Smith, Joel Hopkins. | | |

* Transactions—1952.

- 1874-1875—Francis T. Miles, James A. Steuart, D. A. O'Donnell.
 1875-1876—Christopher Johnston, A. B. Arnold, J. C. Thomas.
 1876-1877—P. C. Williams, James A. Steuart, Francis T. Miles.
 1877-1878—S. C. Chew, F. E. Chatard, Charles H. Jones.
 1878-1879—James C. Thomas, L. McLane Tiffany.
 1879-1880—H. P. C. Wilson, James A. Steuart.
 1880-1881—L. McLane Tiffany, G. Ellis Porter.
 1881-1882—A. H. Bayly, I. E. Atkinson.
 1882-1883—Thomas S. Latimer, Richard McSherry.
 1883-1884—W. Stump Forward, J. S. Lynch.
 1884-1885—John R. Quinan, I. E. Atkinson.
 1885-1886—E. C. Baldwin, J. E. Michael.
 1886-1887—Thomas Opie, Richard Gundry.
 1887-1888—Charles H. Jones, James Carey Thomas.
 1888-1889—J. E. Michael, Thomas P. Evans.
 1889-1890—T. A. Ashby, C. G. W. Macgill.
 1890-1891—Geo. H. Rohé, J. McPherson Scott.
 1891-1892—J. W. Humrichouse, David Streett.
 1892-1893—J. W. Downey, J. W. Chambers.
 1893-1894—John D. Blake, John S. Fulton.
 1894-1895—Charles H. Jones, W. M. Nihiser.
 1895-1896—Charles G. Hill, Clotworthy Birnie.
 1896-1897—Wilmer Brinton, Randolph Winslow.
 1897-1898—W. F. A. Kemp, George J. Preston.
 1898-1899—Mary Sherwood, J. McPherson Scott.
 1899-1900—Samuel Theobald, David Streett.
 1900-1901—Samuel T. Earle, Jr., J. B. R. Purnell.
 1901-1902—Harry Friedenwald, B. W. Goldsborough.
 1902-1903—Samuel T. Earle, Jr., Wilmer Brinton.
 1903-1904—Franklin B. Smith, James M. Craighill.
 1904-1905—Samuel T. Earle, Jr., D. C. R. Miller, Julius A. Johnson.
 1905-1906—Charles O'Donovan, Thomas M. Chaney, Joseph B. Seth.
 1906-1907—William T. Watson, Philip Briscoe, William F. Hines.
 1907-1908—Roger Brooke, Henry L. P. Naylor, George Dobbin.
 1908-1909—Philip Briscoe, William L. Smith, G. Milton Linthicum.
 1909-1910—Philip Briscoe, A. P. Herring, Compton Riely.
 1910-1911—J. Staige Davis, H. B. Gantt, Timothy Griffith.
 1912—J. L. Riley, D. E. Stone, J. A. Chatard.
 1913—J. Staige Davis, C. F. Davison, E. B. Claybrook.
 1914—C. R. Winterson, A. L. Franklin, Gordon Wilson.
 1915—A. McGlannan, J. E. Deets, R. Lee Hall.
 1916—L. C. Carrico, M. D. Norris, J. A. Chatard.
 1917—D. E. Stone, A. H. Hawkins, J. M. H. Rowland.
 1918—Julius Friedenwald, J. E. Deets, J. McF. Dick.
 1919—J. McF. Bergland, Philip Briscoe, J. E. Deets.
 1920—T. R. Boggs, A. M. Shipley, Eugene Jones.
 1921—J. H. M. Knox, Jr., A. H. Hawkins, C. E. Davidson.
 1922—Harry Friedenwald, W. R. White, J. S. Bowen.
 1923—J. M. H. Rowland, Harry Friedenwald, Peregrine Wroth, Jr.
 1924—C. Urban Smith, J. Percy Wade, E. E. Wolff.
 1925—J. S. Bowen, T. B. Johnson, J. McF. Dick.
 1926—Standish McCleary, G. Roger Myers, S. A. Nichols.
 1927—Standish McCleary, John L. Riley, Frank S. Keating.
 1928—J. Albert Chatard, F. B. Hines, R. T. Miller, Jr.
 1929—Henry M. Fitzhugh, Robert P. Bay, Thomas R. Boggs.
 1930—F. D. Chappellear, W. T. Hammond, F. B. Hines.
 1931—W. D. Campbell, H. M. Lankford, Charles Maxson.
 1932—W. T. Hammond, John T. King, Jr., Lewis K. Woodward.
 1933—S. A. Nichols, E. H. Hutchins, W. S. Seymour.
 1934—G. C. Lockard, W. R. White, J. L. Riley.
 1935—J. McF. Dick, Louis Hamman, V. D. Miller.
 1936—Harvey G. Beck, Norman S. Dudley, Jesse O. Purvis.
 1937—Harvey B. Stone, W. A. Gracie, R. Lee Hall.
 1938—Frank S. Lynn, Richard C. Dodson, Everard Briscoe.
 1939—Victor F. Cullen, Frederic V. Beitler, William D. Noble.
 1940—Edward P. Smith, H. A. Cantwell, Charles L. Owens.
 1941—Guy L. Hunner, Charles R. Foutz, R. Lee Hall.
 1942—Maurice C. Pincoffs, Wm. F. Williams, Jacob W. Bird.
 1943—Charles Reid Edwards, A. Austin Pearre, J. Oliver Purvis.
 1944—Alan M. Chesney, William D. Campbell, Hugh R. Spencer.
 1945—William N. Palmer, Harry R. Slack, Armfield F. Van Bibber.
 1946—William D. Noble, Grant E. Ward, John S. Green, Jr.
 1947—Huntington Williams, Frank M. Wilson, J. Herbert Bates.
 1948—William Neill, Jr., Baltimore; Samuel E. Enfield, Cumberland; F. Seton Waesche, Snow Hill.
 1949—Amos R. Koontz, Baltimore; O. H. Binkley, Hagerstown; P. E. Cox, Easton.
 1950—I. Ridgeway Trimble, Baltimore; Vincent H. Davis, Chesapeake City; Thomas K. Galvin, Baltimore.
 1951—Samuel McLanahan, Baltimore; Frank D. Worthington, Frederick; Frank W. Smith, Chestertown.
 1952—Frank J. Geraghty, Baltimore; W. A. Gracie, Cumberland; Deceased 12-28-51; William F. Williams, Cumberland; R. Carmichael Tilghman, Baltimore.

ACTIVE MEMBERS OF COMPONENT SOCIETIES. 1952

Allegheny-Garrett County

Alvarez, Joseph, 101—3rd Street, Oakland
 Ballin, R. W., 62 Greene Street
 Baumgartner, E. I., Oakland, Maryland
 Benjamin, Gilbert W., Hillen Station, W. Md. RR Co., Baltimore 2
 Brings, Elizabeth, La Vale, Maryland
 Brings, Ludwig, 67 Greene Street, Cumberland, Md.
 Broadrup, E. E., 202 Virginia Avenue, Cumberland, Md.
 Cawley, Frank, Memorial Hospital, Cumberland, Md.
 Cooper, Leonard S., Medical Building, Cumberland, Md.
 Cowherd, J. Kile, 41 Greene Street, Cumberland, Md.
 Daugherty, Leslie E., 7 Washington Street, Cumberland, Md.
 Davis, Frank U., 22 Washington Street, Cumberland, Md.
 Davis, John B., 2 Broadway, Frostburg, Maryland
 Davis, N. R., Grantsville, Maryland
 Deming, Herbert V., 125 Bedford Street, Cumberland, Md.
 Diehl, H. C., Frostburg, Maryland
 Dunne, Thomas B., U. S. A. Hospital, Ft. Benning, Ga.
 Durrett, Clay Earl, 236 Virginia Avenue, Cumberland, Md.
 Dyer, John, Randolph A. F. B., Texas
 Eliason, H. W., 126 Union Street, Cumberland, Md.
 Enfield, Samuel E., 116 S. Liberty Street, Cumberland, Md.
 Faw, Wylie M., Jr., 5 Washington Street, Cumberland, Md.
 Fazenbaker, A. J., Westernport, Maryland
 Feaster, James, Oakland, Maryland
 Frantz, Winter R., City Hall, Cumberland, Maryland
 Frye, Paul, Lonaconing, Maryland
 Gardner, Charlotte B., 126 Columbia Street, Cumberland, Md.
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 *Gracie, W. A., 122 S. Centre Street, Cumberland
 Grove, Donald B., Medical Building, Cumberland

Hallinan, James P., 300 Decatur Street, Cumberland, Md.
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 Johnson, James T., Jr., 206 Washington Street, Cumberland, Md.
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 Lusby, Thomas F., II, Oakland, Maryland
 McLane, W. Oliver, Jr., Frostburg, Maryland
 McLean, James E., 49 Greene Street, Cumberland, Md.
 Mance, A. E., Oakland, Maryland
 Mathews, L. B., 49 Greene Street, Cumberland, Md.
 Matthai, Jacob H., 101 S. Centre Street, Cumberland, Md.
 Mirkin, Abraham J., 115 S. Centre Street, Cumberland, Md.
 Moseley, W. E., Mt. Savage, Maryland
 Mozzer, Alexander J., W. Md. R.R., Cumberland, Md.
 Murray, Francis Alan C., 41 Greene Street, Cumberland, Md.
 Myers, L. R., 122 S. Centre Street, Cumberland, Md.
 Owens, Charles L., 122 S. Centre Street, Cumberland, Md.
 *Owens, Maurice E. B., 133 Virginia Avenue, Cumberland, Md.
 Ranson, Leland B., 41 Greene Street, Cumberland, Md.
 Rathbone, Rhett R., 122 S. Centre Street, Cumberland, Md.
 Rees, David T., 404 Decatur Street, Cumberland, Md.
 Reeves, J. Norman, Westernport, Maryland
 Reeves, Raymond W., Westernport, Maryland

Robinson, H. Thomas, Jr., 19 S. Liberty Street, Cumberland, Md.
 Roth, Oliver Ralph, 427 Goethe Street, Cumberland, Md.
 Rothstein, Martin M., Frostburg, Maryland
 Rozum, John Karol, 305 Decatur Street, Cumberland, Md.
 Schindler, Blaine M., 41 Greene Street, Cumberland, Md.
 Simons, George, 128 Union Street, Cumberland, Md.
 Skitarelic, Benedict, Memorial Hospital, Cumberland, Md.
 Snyder, C. F. W., 36 Greene Street, Cumberland, Md.
 Stegmaier, James G., 122 S. Centre Street, Cumberland, Md.
 Tepfer, Milton, Friendsville, Maryland
 Tolson, Howard L., Cumberland, Maryland
 Trevaskis, R. W., 220 Baltimore Avenue, Cumberland, Md.
 Trevaskis, R. W., Jr., 220 Baltimore Avenue, Cumberland, Md.
 Van Ormer, W. Alfred, 531 Louisiana Avenue, Cumberland, Md.
 Walters, Hilda Jane, 48 Broadway, Frostburg, Md.
 Weisman, Saville G., 59 Greene Street, Cumberland, Md.
 Wenzel, J. W., Oak and 8th Streets, Oakland, Md.
 Whitworth, Fuller B., 112 Bedford Street, Cumberland, Md.
 Williams, Richard Jones, 122 S. Centre Street, Cumberland, Md.
 Williams, William F., 122 S. Centre Street, Cumberland, Md.
 Wolferman, Adolf, Frostburg, Maryland
 Zimmerman, Charles Conrad, 105 S. Centre Street, Cumberland, Md.

Anne Arundel County

Alexander, John G., Crain Highway & Second Avenue, Glen Burnie, Md.
 Allen, Aris T., 10 Carroll Street, Annapolis, Md.
 Anderson, Albert L., Annapolis, Maryland

* Deceased.

Ball, Charles L., Jr., Linthicum Heights, Maryland
 Basil, George C., 59 Franklin Street, Annapolis, Maryland
 Beard, J. Howard, Anne Arundel County Health Dept., Annapolis, Maryland
 Benedict, Ludwig, Crownsville, Maryland
 Borssuck, Samuel, Amos Garrett Boulevard, Annapolis, Maryland
 Briscoe, Philip, 212 Prince George Street, Annapolis, Maryland
 Christhilf, Stuart, Jr., 69 Franklin Street, Annapolis, Maryland
 Claffy, John M., 98 Duke of Gloucester Street, Annapolis, Maryland
 Clark, John A., House of Correction, Jessups, Maryland
 Faubert, Gustav H., 5 First Avenue, S.E., Glen Burnie, Md.
 Field, Edward G., 1 Crain Highway, Glen Burnie, Maryland
 French, William J., State Office Building, Annapolis, Maryland
 Gaalaas, A. F., Pasadena, Maryland
 Gould, Vincent, Mayo, Maryland
 Grant, Bowie Linn, Shadyside, Maryland
 Grimaldi, Pasquale John, 4609 Governor Ritchie Highway, Baltimore 25, Maryland
 Grossi, Igino, 201 N.W. Baltimore, Annapolis Blvd., Glen Burnie, Maryland
 Hadley, Henry G., Edgewater, Maryland
 Hooker, Donald, 90 Cathedral Street, Annapolis, Maryland
 *Hopkins, Walton H., Maryland Avenue, Annapolis, Maryland
 Hunt, Barbara, Deale, Maryland
 Jones, Bobby L., 5 Central Avenue, S.W., Glen Burnie, Md.
 Klawans, Maurice F., Southgate Avenue, Annapolis, Maryland
 Klinger, Stephen, Crownsville State Hospital, Crownsville, Maryland
 Linhardt, Elmer G., Eastport, Maryland
 Linthicum, Charles, Linthicum Heights, Maryland
 Lowe, C. Milton, Weston Hospital, Weston, W. Virginia
 MacDonald, Charles R., 7 Central Avenue, Glen Burnie, Md.
 McLaughlin, Randall, Mountain Road, Pasadena, Maryland

McNemar, Oscar H., Millersville, Maryland
 Martin, James R., 185 Prince George Street, Annapolis, Maryland
 Morgenstern, Jacob, Crownsville State Hospital, Crownsville, Maryland
 Ochs, Irving L., 51 Southgate Avenue, Annapolis, Maryland
 Purvis, Jesse Oliver, 40 Franklin Street, Annapolis, Maryland
 Richardson, R. L., 110 Clay Street, Annapolis, Maryland
 Ritchings, Edward Peyton, P. O. Box 4863, Louisville, Kentucky
 Russell, John T., Eastport, Maryland
 Shipley, Frank M., 63 College Avenue, Annapolis, Maryland
 Skerritt, Edward G., Millersville, Maryland
 Sosnowski, A. R., 4016 Ritchie Highway, Baltimore 25, Md.
 Tobler, Alice Berg, Anne Arundel County Medical Society, Annapolis, Maryland
 Thomas, William V., Jr., N. Franklin Street, Annapolis, Md.
 Tretlin, J. Douglas, Severna Park, Maryland
 Trevett, Elizabeth Peabody, 240 Prince George, Annapolis, Maryland
 Walden, Robert C., 59 Central Avenue, S.W., Glen Burnie, Maryland
 Weitzman, F. E., West Street, Annapolis, Maryland
 Welch, Robert S. G., Annapolis, Maryland
 Wilkins, Jesse Lee, 232 Prince George Street, Annapolis, Maryland
 Willoughby, M. K., Ritchie Highway at Sand Rock Bldg., Severna Park, Maryland
 Wilson, Emily H., Harwood, Maryland
 Wright, J. LeRoy, Cockeysville, Maryland
 Zangara, H. F., University Hospital, Baltimore 1, Maryland

Baltimore County

Allison, Robert Herschel, 4 Burkleigh Square, Towson 4, Md.
 Andrew, David Holmes, 5410 Willowmere Way, Baltimore 12, Md.
 Armacost, Joshua H., 6419 Windsor Mill Rd., Woodlawn 7, Md.

Bacon, A. M., 2810 Taylor Ave., Parkville 14, Md.
 Baier, John C., 3901 Northern Pkwy., Baltimore 6, Md.
 Barstow, Mary V. M., Glyndon, Md.
 Beck, Irving R., 901 Fuselage Ave., Baltimore 20, Md.
 Baumgardner, George M., 8552 Philadelphia Road, Baltimore 6, Md.
 Beitler, Frederic V., Medical Arts Bldg., Baltimore 1, Md.
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 Bing, Richard J., Medical College of Alabama, Dept. of Experimental Medicine and Clinical Pathology, Birmingham, Alabama
 Block, Nathan, 7011 Deerfield Rd., Pikesville 8, Md.
 Bociak, Stanley, 7009 Dunmanway, Dundalk 22, Md.
 Bridges, Wm. A., Otho Ridge Road, Towson 4, Md.
 Brown, Lida Crockett, Sheppard-Pratt Hospital, Towson 4, Md.
 Brown, Seymour M., 45 Edgewater Apts., Baltimore 21, Md.
 Bubert, John D., Wyman Park Apts., Apt. 208, Beech Ave. & 40th, Baltimore 10, Md.
 Burns, Harold Hubert, 115 E. Eager St., Baltimore 2, Md.
 Burns, John Howard, 59 Dundalk Ave., Dundalk 22, Md.
 Burton, Charles H., 225 Northway, Baltimore 18, Md.
 Butler, Harry G., Rosewood State Training School, Owings Mills, Md.
 Cameron, Joseph J., 25-C Oak Grove Drive, Baltimore 20, Md.
 Caples, D. Delmas, 6 Hanover Road, Reisterstown, Md.
 Carmine, Walter M., 88 Baltimore Ave., Dundalk 22, Md.
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 Chance, Lester T., 11 E. Chase St., Baltimore 2, Md.
 Cianos, James Nicholas, 1225 N. Calvert St., Baltimore 2, Md.
 Clarke, Sydenham Rush (Emeritus), E. Morris Ave., Lutherville, Md.
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 Cushing, Jean George N., 11 E. Chase St., Baltimore 2, Md.
 Cushing, Mary McK., 11 E. Chase St., Baltimore 2, Md.

- Dalmau, Louis Z., 1413 Reisterstown Rd., Pikesville 8, Md.
- Dausch, Michael J., 4636 Belair Rd., Baltimore 6, Md.
- Davens, Edward, 2411 N. Charles St., Baltimore 18, Md.
- Davis, George H., 404 Hollen Rd., Baltimore 12, Md.
- Davis, Melvin B., 2910 Dunleer Rd., Dundalk 22, Md.
- D'Elia, Laurence N., 2200 Pleasant Villa Rd., Baltimore 28, Md.
- Dunton, William R. (Emeritus), 33 N. Symington Rd., Baltimore 28, Md.
- Durlacher, Stanley H., 934 Dulaney Valley Rd., Towson 4, Md.
- Eichert, Arnold H., 44 Maple Drive, Baltimore 28, Md.
- Ensor, Charles B., 7201 York Rd., Baltimore 12, Md.
- Estep, Paul R., Riverdale Apts., 2 Fenway St., Baltimore 21, Md.
- Evans, Eugene R., 1 Liberty Parkway, Dundalk 22, Md.
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- Farber, Mary S., 914 D Street, Sparrows Point 15, Md.
- Farber, Robert E., 914 D Street, Sparrows Point, Md.
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- Francis, John Joseph, 1523 Stonewood Rd., Baltimore 12, Md.
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- Gill, Hugh C. F., 3708 Buckingham Rd., Baltimore 7, Md.
- Glantz, Frank A., 7 Wendover Rd., Baltimore 18, Md.
- Gonzalez, Caridad Emiliana, 2911 Emerald Ave., Baltimore 14, Md.
- Goodman, William, 1334 Sulphur Spring Rd., Arbutus 27, Md.
- Grau, Edward Gordon, 8523 Loch Raven Blvd., Towson 4, Md.
- Green, John S., Jr., 28 Alleghany Ave., Towson 4, Md.
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- Hammett, Walter M., Baldwin, Md.
- Hening, R. M., 203 Ingleside Ave., Catonsville 28, Md.
- Hetherington, Leon, 12 Darnell Rd., Ruxton 4, Md.
- Hiller, Grace, 401 Brook Rd., Towson 4, Md.
- Hills, Arthur Gorman, 228 S. Quince St., Philadelphia, Pa.
- Hollander, Mark, 817 St. Paul St., Baltimore 2, Md.
- Howell, Clewell, 102 Alleghany Ave., Towson 4, Md.
- Howell, James G., 715 Frederick Ave., Catonsville 28, Md.
- Hudson, Clifford F., Fork, Md.
- Hudson, Rollin C., 606 Baltimore Ave., Towson 4, Md.
- Johns, George A., Rosewood Training School, Owings Mills, Md.
- Johns, Viola B., Rosewood Training School, Owings Mills, Md.
- Johnson, Arthur L., 423 New Pittsburgh Avenue, Baltimore 22, Md.
- Johnson, S. Lloyd, 610 Frederick Rd., Catonsville 28, Md.
- Junk, Ivan DeKalb, 3636 Forest Hill Avenue., Baltimore 7, Md.
- Kerr, Charles M., 6801 Belair Road, Baltimore 6, Md.
- Kees, Walter T., Cockeysville, Md.
- Kenworthy, Richard Albert, III, Locust Avenue, Ruxton 4, Md.
- Kieffer, George S. M., 1010 Leeds Ave., Baltimore 29, Md.
- Kolodny, A. L., 21 Cedar Drive, Baltimore 20, Md.
- Landau, Walter S., 23 Hanover Rd., Reisterstown, Md.
- Lyon, Wm. Cochran, 2011 Greenberry Rd., Baltimore 9, Md.
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- Magness, Stephen L., 908 Frederick Ave., Catonsville 28, Md.
- Martin, William E., Randallstown, Md.
- Means, James Thomas, 514 C Street, Sparrows Point 19, Md.
- Medairy, George C., Rosewood Sanatorium, Owings Mills, Md.
- Merrill, George G., 100 East Chase St., Baltimore 2, Md.
- Miceli, Joseph, 422 Eastern Ave., Baltimore 21, Md.
- Miller, James A., Reisterstown Rd. & Walker Ave., Pikesville 8, Md.
- Morrison, W. Herbert, 3 Kingships Rd., Dundalk 22, Md.
- Mund, Maxwell H., 417½ Eastern Ave., Essex 21, Md.
- Murdock, Harry Merrill, Sheppard-Pratt Hospital, Towson 4, Md.
- Nevy, Eugene Francis, 7001 Mornington Road, Dundalk 22, Md.
- Newcomer, William, Mt. Wilson, Md.
- Newell, H. Whitman, 601 W. Lombard St., Baltimore 1, Md.
- Nichols, Elijah E., 1402 Reisterstown Rd., Pikesville 8, Md.
- Nichols, Joseph Harold, 747 S. Avondale Rd., Baltimore 22, Md.
- Noguera, John F., Kingsville, Md.
- Nolan, James, 5804 Edmondson Ave., Baltimore 28, Md.
- Novey, Samuel, 1114 Medical Arts Bldg., Baltimore 1, Md.
- O'Donnell, Charles Francis, 7301 York Rd., Baltimore 4, Md.
- Parr, William A., 1225 North Calvert St., Baltimore 2, Md.
- Parson, Willard S., 1711 Selma Ave., Halethorpe 27, Md.
- Patton, John S., Sheppard & Enoch Pratt Hospt., Box 6815, Towson 4, Md.
- Peal, Stanley, 11 E. Chase St., Baltimore 2, Md.
- Perkins, Clifton T., 646 Charles St., Towson 4, Md.
- Peterman, James Elmer, 1733 E. 35th St., Baltimore 18, Md.
- Pierpont, Edwin L., 8027 Liberty Rd., Baltimore 7, Md.
- Post, Lawrence Caldwell, 6805 York Rd., Baltimore 12, Md.
- Pound, John Costello, 104 N. Rolling Rd., Baltimore 28, Md.
- Reese, J. Morris, Lutherville, Md.
- Rehberger, John M., Phoenix, Maryland
- Reier, Charles H., Dunkirk & York Rd., Anneslie 12, Md.
- Richards, C. Victor, 321 Dunkirk Rd., Anneslie 12, Md.
- Riley, Robert H., 100 N. Beechwood Ave., Catonsville 28, Md.
- Roberts, Dean W., 811 Trafalgar Rd., Towson 4, Md.
- Roop, Donald, 3810 Oake Ave., Baltimore 7, Md.

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Runkel, John G., Spring Grove
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Sedlack, Joseph Arthur, 200 W. Penn-
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Sherrill, Elizabeth B., Cockeysville,
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Weems, George Jones, Huntingtown,
Md.

Caroline County

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Lennon, W. E., Federalsburg, Md.
Plummer, Harold B., Preston, Md.
Silver, H. Fletcher, Goldsboro, Md.
Stonesifer, Charles H., Greensboro,
Md.
White, George S., Ridgely, Md.
Winnacott, Charles H., Ridgely, Md.
Wright, James F., Denton, Md.
Wright, Robert, Greensboro, Md.

Carroll County

Bare, S. Luther, Westminster, Md.
Benner, Chandos M., Taneytown,
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Bradley, W. P., Taneytown, Md.

Bush, Edgar Murray, Hampstead,
Md.
Bush, Joseph E., Hampstead, Md.
Chepko, Julius, Westminster, Md.
Culwell, William, Mt. Airy, Md.
Foard, Wilbur H., Manchester, Md.
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 McPherson, H. F., Centreville, Md.
 Martin, William G., Jr., Queenstown, Md.
 Miller, Robert B., Centreville, Md.
 Sattelmair, Theodor, Stevensville, Md.
 Shepherd, Frederick T., Queenstown, Md.

St. Mary's County

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 Boyd, William D., Leonardtown, Md.
 Camalier, F. A., Leonardtown, Md.
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 Greenwell, Francis Floyd, Leonardtown, Md.
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 Coulbourn, George C., Marion Station, Md.
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 Seymour, W. S., Trappe, Md.
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March 31, 1951–March 31, 1952

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 Benson, John Fisher, 5111 York Road—12
 Berdiansky, Benjamin, Ft. Sam Houston, Texas
 Bereston, Eugene S., 2406 Eutaw Place—17
 Bergland, John McF., 1014 St. Paul St.—2
 Berman, Edgar F., 809 Cathedral St.—1
 Bernheim, Bertram M., 2424 Eutaw Place—17
 Bernstein, Alan, 1109 N. Calvert St.—2
 Bernstein, Milton, 3302 Clarkes Lane—15
 Berry, Robert Zinn, 3552 Broad Street, Phila., Pa.
 Betz, Barbara J., 1503 Bolton Street—17
 Bianco, John J., 1114 St. Paul Street—2
 Biehl, Harold Paul, 11 E. Chase Street—2
 Billups, Gaius W., 504 Murdock Road—12
 Bindeman, William Wylie, 4007 Carlisle Avenue—16
 Bing, James F., 715 Park Avenue—1
 Bird, Joseph Gordon, Northwood Professional Center, 1532 Havenwood Road—18
 Bishop, G. W., Sheridan Ave. and York Rd.—12
 Bix, Hans, 2516 Linden Ave.—17
 Blair, Emil, Baltimore City Hospitals—24
 Blake, Herbert C., Medical Arts Bldg.—1
 Blalock, Alfred, Johns Hopkins Hospital—5
 Blazek, Charles Joseph, 101 E. Biddle Street—2
 Blechman, A. Joel, 3426 Bank Street—24
 Block, Walter P., 509 Drury Lane—29
 Blum, Joseph S., 1115 N. Calvert Street—2
 Blum, Louis V., 2310 Eutaw Place—17

Bodenheimer, Ernst, 1212 Eutaw Place—17
 Bogorad, Daniel E., 1905 W. Baltimore St.—23
 Bohlman, Harold R., Medical Arts Bldg.—1
 Bokhair, Lee, Maryland General Hospital—1
 Bongardt, Henry F., 201 W. Madison St.—1
 Borden, Jesse N., 1109 N. Calvert Street—2
 Borden, Melvin N., 5000 Old Frederick Road—29
 Bordley, James, Jr., 330 N. Charles St.—1
 Bordley, John Earle, 330 N. Charles St.—1
 Borges, Francis Joseph, 2528 Maryland Avenue—18
 Borkovich, Katherine H., 11 E. Chase Street—2
 Boss, M. Theodore, Medical Arts Bldg.—1
 Bossyns, Albert J., 4122 Kathland Ave.—7
 Bowe, Dudley P., 2 W. Read St.—1
 Bowie, Harry Clay, 1011 N. Calvert Street—2
 Bowie, Helen, 916 W. University Parkway—10
 Bowyer, Thomas S., Medical Arts Bldg.—1
 Boyd, Charles Holmes, 24 E. Eager Street—2
 Boyd, Kenneth B., 1114 St. Paul Street—2
 Boyle, John Brook, Jr., 1226 St. Paul Street—2
 Brack, Charles Bernard, 11 E. Chase St.—2
 Brackin, John T., Jr., Veterans Hospital, Fort Howard, Md.
 Bradley, J. Edmund, University Hospital—1
 Brady, Frank Joseph, 4530 Marble Hall Road—12
 Brady, Leo, Medical Arts Bldg.—1
 Brager, Simon, 1800 N. Charles St.—1
 Brailey, Miriam Esther, Harriet Lane Hospital—5
 Branon, A. Brooks, Cambridge Arms Apartments—18
 Brantigan, Otto C., 104 W. Madison St.—1
 Breitstein, Moses L., 1212 Eutaw Place—17
 Brendle, William K., Maryland General Hospital—1

Brennan, Thomas J., 5217 Harford Road—14
 Brickman, Helen Cicely, Hospital for the Women of Maryland—17
 Bridgman, E. W., 11 E. Chase St.—2
 Brinsfield, Carlton, 1231 Gleneagle Road—12
 Bronos, George J., 507 Castle Drive—12
 Bronushas, I. Benedict, 3037 O'Donnell St.—24
 Bronushas, Joseph B. Bernard, 3037 O'Donnell St.—24
 Brooks, Ross C., 2512 E. Monument Street—5
 Brouillet, George H., 102 Dunkirk Road—12
 Brown, Ernest Claiborne, Jr., 1101 N. Calvert Street—2
 Brown, James, Jr., Medical Arts Bldg.—1
 Brown, Paul, 3602 Liberty Heights Ave.—17
 Brown, Webster H., 11 E. Biddle Street—2
 Browne, James S., University Hospital—1
 Browne, Rayner, 1500 E. Madison Street—5
 Broyles, Edwin N., 1100 N. Charles St.—1
 Brumback, Frank Edgar, 1339 Pentwood Road—12
 Brumback, Joseph E., Medical Arts Bldg.—1
 Brumback, Joseph E., Jr., 201 Edgevale Road—10
 Bubert, Howard M., Medical Arts Bldg.—1
 Buchness, Anthony V., 110 E. Lombard St.—2
 Buchness, John A., 110 E. Lombard St.—2
 Buck, Walter B., 18 E. Eager St.—2
 Bunce, Paul L., 626 N. Washington Street—5
 Bundick, William R., 840 Park Avenue—1
 Burger, T. Terry, 3301 N. Charles St.—18
 Burgin, Bernard, 6721 Reisterstown Road—15
 Burnett, Jack M., 1401 Stonewood Road—12
 Butler, W. Berkley, 2033 Druid Hill Avenue—17
 Byerly, Marshall P., 3033 W. North Ave.—16
 Cahn, Charles A., 2145 W. Baltimore St.—23

- Camp, Leah Rosenblatt, 3321 Sequoia Avenue—15
- Camp, Oscar B., 3705 Liberty Heights Avenue—15
- Campbell, Charles R., 718 Dolphin Street—17
- Cannon, Burdelle Sittler, 509 Medical Arts Bldg.—1
- Cantrell, James R., Johns Hopkins Hospital—5
- Caplan, Lester H., 4208 Colonial Road—8
- Carey, T. Nelson, 1014 St. Paul St.—2
- Carliner, Paul Elliott, 2217 South Rd.—9
- Carman, Richard Perry, 3602 Frederick Avenue—29
- Carozza, Anthony F., 5217 York Rd.—12
- Carr, Charles E., 6007 York Road—12
- Carr, James D., 1427 Madison Avenue—17
- Carroll, H. Roland, 4202 Charlcote Road—18
- Carter, Lucille Price, 203 Hilltop Road, Silver Spring, Md.
- Casler, DeWitt B., 13 W. Chase St.—2
- Castagna, Joseph V., 1011 N. Charles Street—2
- Chalfant, A. Stuart, 6210 York Rd.—12
- Chambers, Earl Leroy, 4108 Liberty Heights Ave.—7
- Chambers, Ewan Buchanan, 12 York Road, York Road at Burke Ave., Towson
- Chambers, John W., 18 W. Franklin St.—1
- Chambers, Robert George, 945 Ellicott Driveway—16
- Chambers, Thomas R., 18 W. Franklin St.—1
- Chant, Harry L., Johns Hopkins Hospital—5
- Chase, William Edward, 1109 Nix Professional Building, San Antonio 5, Texas
- Chatard, Ferdinand Edme, IV, 15 E. Biddle Street—2
- Chatard, J. Albert, 15 E. Biddle Street—2
- Checket, Pierson M., 1801 Eutaw Place—17
- Chenowith, Robert Franklin, 1114 St. Paul St.—2
- Chesney, Alan M., 1419 Eutaw Place—17
- Chiodi, Nathan E., 11 E. Chase Street—2
- Chisolm, J. J., 6 E. Eager Street—2
- Clapp, Clyde A., 513 N. Charles St.—1
- Clark, Fred Harlow, 3610 Gwynn Oak Ave.—7
- Classen, John Newell, 2934 N. Calvert Street—18
- Cleary, Louis F., 6420 Reisterstown Road—15
- Clemson, Earl P., 701 Cathedral Street—1
- Clough, Paul W., 24 E. Eager St.—2
- Cobb, John Candler, 615 N. Wolfe Street—5
- Coblentz, R. G., Latrobe Apts.—2
- Cohen, Bernard J., Marlborough Apts.—17
- Cohen, Harry, 803 Cathedral Street—1
- Cohen, Irvin H., 4017 Annellen Road—15
- Cohen, Jonas Harold, 5901 Park Heights Avenue—15
- Cohen, Morris M., 1115 St. Paul Street—2
- Cohn, L. Clarence, 3301 N. Charles St.—18
- Cole, Alfred, 136 S. Hilton Street—29
- Cole, John Wesley, 6604 Loch Raven Boulevard—Towson 4
- Cole, Norman Brown, University Club—1
- Coleman, William J., 2810 Chelsea Terrace—16
- Collenberg, H. T., 2 W. Read St.—1
- Collins, James M., 3321 Frederick Ave.—29
- Colsky, Jacob, 6129 Parkway Drive—12
- Colston, J. A. C., 1201 N. Calvert St.—2
- Compton, Beverley C., 1014 St. Paul Street—2
- Compton, J. Richard, Woman's Hospital—17
- Conley, C. Lockard, 120 E. Lake Avenue—12
- Conn, Jacob Harry, 2325 Eutaw Place—17
- Connolly, Harry John, 13 East Eager St.—2
- Constadt, Hans Walter, 814 Medical Arts Bldg.—1
- Cook, Elmer E., 2431 Maryland Avenue—18
- Cook, Sarah, 2609 Lee Boulevard, Apt. 202, Arlington 4, Va.
- Cooley, Robert N., Johns Hopkins Hospital—5
- Cooper, Theodore, 2201 Eutaw Place—17
- Copeland, Herbert B., 2237 Eutaw Place—17
- Cordi, Joseph M., 1261 E. Belvedere Avenue—12
- Cornbrooks, Ernest I., Jr., Medical Arts Bldg.—1
- Costantini, John, 234 S. Conkling Street—24
- Cotter, Edward Francis, 11 E. Chase Street—2
- Cotton, Albertus, 101 E. Preston St.—2
- Council, Wilfred A., 1246 Sacramento Street, San Francisco, Calif.
- Covington, E. Eugene, 828 Park Avenue—1
- Cox, William Franklin, 3rd, 231 E. University Parkway—18
- Crimy, Charles P., 2722 E. Monument St.—5
- Crocker, Melvin Hugh, 1204 St. Paul Street—2
- Crosby, Edwin L., Johns Hopkins Hospital—5
- Cross, Ernest S., 1035 N. Calvert St.—2
- Cross, Ernest S., Jr., 4408 Atwick Road—10
- Cross, Richard J., Randolph Field, Texas
- *Crouch, J. Frank, The Latrobe Apts.—2
- Crowe, Samuel J., 4332 N. Charles St.—18
- Crowther, Aloho H., 4209 Frederick Ave.—29
- Cullen, Thomas Stephen, 20 E. Eager St.—2
- Cumin, Milton H., 4302 Springdale Avenue—7
- Cunningham, Raymond M., 11 E. Chase St.—2
- Currie, Dwight McL., 11 E. Chase St.—2
- Curtis, Raymond M., 113 Beechdale Road—10
- Dana, Edward R., 5704 Beauregard Avenue—12
- Daniels, Thomas F., 6 E. Eager St.—2
- D'Antonio, Joseph, 600 Franklin Avenue, Essex—21

- Darby, William Arthur, Medical Arts Bldg.—1
- Daugharthy, A. Bradley, 1264 Francis Avenue, Halethorpe
- Davidov, Nathan J., 3218 Eastern Avenue—24
- Davidson, Charles Nuchols, Medical Arts Bldg.—1
- Davidson, Nachman, 812 Park Avenue—1
- Davies, Arthur J., 800 W. 33rd St.—11
- Davis, E. Hollister, 3301 N. Charles Street—18
- Davis, Frank Willard, 824 Argonne Drive—18
- Davis, John R., Jr., Medical Arts Building—1
- Davis, Marvin Hersch, 408 Swann Avenue, Apt. D.—29
- Davis, William Bowdoin, 701 Cathedral Street—1
- Day, Newland Edward, 4 E. 33rd Street—18
- Deane, Garrett E., University Hospital—1
- Debuskey, Matthew, 2412 Eutaw Place—17
- DeCarlo, John, Jr., 1211 Cochran Avenue—12
- Deckert, William Allen, 1114 St. Paul St.—2
- De Hoff, George W., 2020 N. Charles St.—18
- De Hoff, John Burling, 2020 N. Charles St.—18
- Deibel, Harry, 1224 Hanover Street—30
- Delfs, Eleanor, Johns Hopkins Hospital—5
- Demarco, Salvatore, Jr., 715 N. Charles Street—1
- Dennis, John Murray, University Hospital—1
- Denny, Walter L., The Walbert Apts.—1
- De Vincentis, Michael Louis, 11 E. Chase Street—2
- Dickey, Francis G., 736 Northern Parkway—12
- Dickson, Lawrie C., Jr., 493 St. Clair Avenue, Grosse Point, 30, Michigan
- Diehl, William K., 11 E. Chase St.—2
- Diener, Louis, 2449 Eutaw Place—17
- Diggs, Everett S., 11 E. Chase Street—2
- Di Paula, Anthony F., 11 E. Chase Street—2
- Dix, Harold C., 405 N. Charles St.—1
- Dixon, Alfred B., 229 E. 33rd Street—18
- Dixon, Darius McClelland, Medical Arts Bldg.—1
- Dixon, William Thomas, 3704 N. Charles Street—18
- Dobihal, Louis Charles, 447 N. Kenwood Ave.—24
- Dodd, William A., 700 N. Charles Street—1
- Doeller, Charles Henry, Jr., 1025 N. Calvert Street—2
- Doran, William T., Jr., 221 W. Lanvale Street—17
- Dorf, Herman J., 3103 Garrison Blvd.—16
- Dorman, John William, Jr., 3101 St. Paul St.—19
- Douglass, Carleton Cecil, 1201 N. Calvert Street—2
- Douglass, Louis H., University Hospital—1
- Drenga, Joseph F., 209 S. Chester Street—31
- Drozd, Joseph, 2601 Eastern Ave.—24
- Duffy, William C., 1120 St. Paul Street—2
- Dugan, Hammond J., Jr., 15 E. Biddle Street—2
- Dunnigan, William C., 4916 Harford Rd.—14
- Dwyer, Frank P., Jr., 431 Greenlaw Road—28
- Eadie, Frederick Stearns, Baltimore City Hospitals—24
- Eareckson, Vincent O., Jr., 2309 Elsinor Avenue—16
- Eastland, John Sheldon, Medical Arts Bldg.—1
- Eastman, Nicholson J., Johns Hopkins Hospital—5
- Eaton, George O., 4 E. Madison St.—1
- Eaton, W. Drummond, 11 E. Chase St.—2
- Ebeling, Karl W., 3311 St. Paul St.—18
- Ebeling, William Carl, Massachusetts General Hospital, Boston 14, Mass.
- Edel, John W., Jr., 3403 Garrison Ave.—15
- Edgerton, Milton T., Johns Hopkins Hospital—5
- Edlow, Ernest S., 2353 Eutaw Place—17
- Edmunds, Page, 4417 Underwood Road—18
- Edwards, C. Reid, Medical Arts Bldg.—1
- Edwards, Monte, Medical Arts Bldg.—1
- Egerton, Stuart W., 11 E. Chase St.—2
- Ehrlich, Daniel, 3911 Wabash Avenue—15
- Eisenberg, Albert, 2025 E. North Ave.—13
- Eisenberg, Leon, 1801 W. Baltimore Street—23
- Elder, John D., Jr., 200 Montrose Avenue—28
- Eleder, Franklin Charles, 2201 Echo-dale Avenue—14
- Elgin, William Worcester, Sheppard and Enoch Pratt Hospital, Towson—4
- Ellis, Francis A., 8 E. Madison St.—2
- Ellison, Emanuel S., 107 E. West St.—30
- English, Max R., 5713 Bel Air Rd.—6
- Ephraim, Meyer, 443 E. 25th St.—18
- Erwin, John J., Medical Arts Bldg.—1
- Evans, John, Medical Arts Bldg.—1
- Everett, Houston Spencer, 11 E. Chase St.—2
- Ewald, August L., 36 York Court—18
- Farber, George J., 1037 St. Paul Street—2
- Fargo, Lee K., 1800 N. Charles St.—1
- Farley, Julie, 418 Northway—18
- Fearing, William Lumsden, 3025 Belair Rd.—13
- Feinglos, Israel J., 2002 E. Pratt St.—31
- Feldman, Maurice, 747 Lake Drive—17
- Feldman, Maurice, Jr., The Latrobe Apartments—2
- Fenby, John S., 3522 Greenmount Ave.—18
- Ferguson, W. Richard, 1107 St. Paul Street—2
- Field, Arnold Lewis, 901 Cathedral Street—1
- Filtzer, David Leonard, 1411 Eutaw Place—17
- Fine, Morris A., 118 Aisquith St.—2
- Fineman, Jerome, 3700 Garrison Boulevard—15
- Finesinger, Jacob Ellis, Dept. of Psychiatry, Univ. of Md. School of Medicine—1
- Finkelstein, Abraham H., 11 E. Chase St.—2
- Finkelstein, Ruth, Medical Arts Building—1
- Finney, George Gross, 2947 St. Paul St.—18
- Finney, John M. T., Jr., 2947 St. Paul St.—18
- Firor, Warfield M., 1101 N. Calvert Street—2

Firor, Whitmer B., 1100 N. Charles St.—1
 Fischer, Newton D., Box 198, Johns Hopkins Hospital—5
 Fishel, Elliott Raphael, 821 Chauncey Avenue—17
 Fisher, A. Murray, 18 E. Eager St.—2
 Fisher, William A., Jr., 20 Blythewood Road—10
 Fitzpatrick, Vincent de Paul, Jr., 1120 St. Paul Street—2
 Fleck, Harvey K., 2940 Wyman Parkway—11
 Fleischer, Walter E., 3400 E. Chase St.—13
 Flippin, Eugene L., 2612 Elsinore Ave.—16
 Flynn, Philip Daniel, 11 E. Chase Street—2
 Ford, James Arthur, Union Memorial Hospital—18
 Fordyce, Cless Y., Medical Arts Bldg.—1
 Forsythe, Hugh, 424 E. North Ave.—2
 Fort, Wetherbee, 20 E. Preston St.—2
 Foster, Herbert M., 2824 St. Paul St.—18
 Fox, Lay Martin, 33A Oak Grove Drive—20
 Fox, Samuel Louis, 1205 St. Paul St.—2
 Frank, Jerome D., 603 W. University Parkway—10
 Franklin, David, 122 W. Lee St.—1
 Franklin, Haswell D., 1123 St. Paul St.—2
 Franz, J. Howard, 1127 St. Paul Street—2
 Freedom, Leon, 1031 St. Paul St.—2
 Freeman, Norman Randolph, Jr., 210 Northway—18
 *French, Bernard S., 2329 Arunah Ave.—16
 Frenkil, James, 1422 Park Ave.—17
 Frey, Edward L., Jr., 2 W. Read St.—1
 Frey, E. William, 1928 Pennsylvania Ave.—17
 Fried, Hiram, Medical Arts Bldg.—1
 Friedenwald, Edgar B., 1616 Linden Ave.—17
 Friedenwald, Jonas S., 1212 Eutaw Place—17
 Friedman, Hyman P., 1319 Light St.—30

Friedman, Joseph, 404 E. North Avenue—2
 Friedman, Marion, 1737 E. North Avenue—13
 Friedman, Paul N., 3804 Fairview Avenue—16
 Fuller, Harvey L., 5718 Ridgedale Road—9
 Furstenberg, Frank F., 812 Park Avenue—1
 Fusting, William H., 11 E. Chase Street—2
 Futch, Palmer H., Department of Medicine, Johns Hopkins Hospital—5
 Futterman, Perry, Latrobe Apartments—2
 Gaber, Jerome, 3239 Powhatan Avenue—16
 Gaither, Ernest H., 12 E. Eager St.—2
 Gallant, Leonard J., The Latrobe Apartments—2
 Galvin, Gerald A., 5652 Woodmount Avenue—18
 Galvin, Thos. K., 113 W. Monument St.—1
 Ganey, Joseph B., University Hospital—1
 Gann, Mark E., 2800 Lawina Rd.—16
 Gareis, Louis C., 1651 Northwick Court—18
 Garis, Robert William, 1103 St. Paul Street—2
 Garlick, William L., 2 W. Read Street—1
 Garrett, Richard M., Medical Arts Building—1
 Garrison, Alfred S., 4605 Edmondson Avenue—29
 Gaskel, Jason H., 637 S. Conkling St.—24
 Gaver, Leo J., 1 Mallow Hill Ave.—29
 Gay, Leslie Newton, 1114 St. Paul St.—2
 Gehlert, Sidney R., 4700 Pennington Avenue—23
 Gellman, Moses, 1411 Eutaw Place—17
 Genecin, Abraham, 1406 Eutaw Place—17
 Geraghty, Francis Jos., 3047 St. Paul St.—18
 Geraghty, Wm. R., 2225 St. Paul St.—18
 Gerlach, James Johnson, 2 Warrenton Road—10
 Gibbons, J. Robert, 3 Elmhurst Rd.—10

Gibbs, Gordon E., University Hospital—1
 Giering, Herman J., 3906 Parkside Drive—6
 Gilkes, Evan A., 601 N. Calhoun Street—17
 Gillis, Andrew Colin, 1033 N. Calvert St.—2
 Gillis, Francis W., 1800 N. Charles Street—1
 Gilmore, William E., 108 E. 33rd Street—18
 Gimbel, Harry S., 2703 Edmondson Avenue—23
 Ginsberg, Milton, 3504 Erdman Ave.—13
 Ginsburg, Leon, 529 North Charles St.—1
 Glass, Frederick Arthur, 845 Park Ave.—1
 Glassman, Lionel, 5700 Cross Country Blvd.—9
 Glick, Samuel S., 3914 Park Heights Ave.—15
 Gluck, Francis Wilcox, 3406 St. Paul Street—18
 Gluck, Julius E., 5356 Reisterstown Road—15
 Goldbach, Leo John, 6 E. Eager St.—2
 Goldberg, Herman K., 719 N. Charles Street—1
 Goldberg, Raymond B., 803 Cathedral Street—1
 Goldberg, Sigmund, 1422 Park Ave.—17
 Goldberg, Sylvan D., 4412 Elderon Avenue—15
 Goldberg, Victor, 3100 Harford Rd.—18
 Goldman, Abram, 3901 Fordleigh Road—15
 Goldman, Harris, 1816 W. North Ave.—17
 Goldman, Harry, 2326 Eutaw Place—17
 Goldsborough, Charles R., 2923 St. Paul St.—18
 Goldsmith, Harry, 3023 Hanlon Ave.—16
 Goldstein, A. E., 3505 N. Charles St.—18
 Goldstein, Eugene O., 3911 Brookhill Road—15
 Goldstein, Marvin, 5334 Liberty Heights Avenue—7
 Goldstone, Herbert, 1810 Eutaw Place—17

Golley, Kyle W., 5103 Harford Rd.—14
 Golombek, Leonard H., 227 Audrey Lane—Apt. 102, Washington 20, D. C.
 Goodman, Howard, 1513 N. Milton Ave.—13
 Goodman, Jerome Edward, 809 Cathedral St.—1
 Goodman, Julius H., 3400 East Baltimore St.—24
 Goodman, Louis E., 1211 Eutaw Place—17
 Goodman, Sylvan Chauncey, 707 Lake Drive—17
 Gordon, Harry H., Sinai Hospital—5
 Gordy, Lyle L., 5106 Harford Rd.—14
 Gorten, Martin K., 4 E. 32nd Street—18
 Gould, John Joseph, 14 N. East Ave.—24
 Govatos, George, Med. Arts Bldg.—1
 Govons, Sidney Robert, 3923 W. Rogers Ave.—15
 Grafflin, Arthur L., 300 Club Road—10
 Graham, Robert Lee, 1027 Summit Drive, Beverly Hills, Cal.
 Graham, R. Walter, 1014 St. Paul St.—2
 Granoff, Hymen L., 2240 Eutaw Place—17
 Gray, Watson W., 1014 St. Paul St.—2
 Graziano, Theodore J., 4019 Alameda Boulevard—18
 Greenberg, Sahler M., 4613 Eastern Ave.—24
 Greif, Roger Louis, 3 Slade Avenue—8
 Grempler, Walter E., 1013 Poplar Grove St.—16
 Grenzer, William H., 1520 E. 33rd Street—18
 Grimes, S. Butler, 100 W. University Pkwy.—10
 Grob, David, 600 W. 37th Street—11
 Grose, William Edwin, 11 E. Chase St.—2
 Gross, Joseph Bernard, 2404 Eutaw Place—17
 Grossman, I. Karl, 1212 N. Patterson Park Ave.—13
 Grott, Harold Allan, 8100 Harford Rd.—14
 Grubb, Wilson Lyon, 4 E. 33rd Street—18
 Grumbine, Francis L., 4011 Edgewood Road—15
 Gubnitsky, Albert, 415 Park Heights Avenue—15

Gundersheimer, Herbert N., Cordova Apartments, Lake Drive—17
 Gundry, Lewis P., 1014 St. Paul St.—2
 Gundry, Rachel K., Athol, Catonsville—29
 Gusock, Milton, 108 E. Milbourne Avenue, Silver Spring, Md.
 Gutman, Isaac, 817 St. Paul St.—2
 Gutmacher, Manfred S., 1109 N. Calvert St.—2
 Guyton, Jack Smallwood, Johns Hopkins Hospital—5
 Guyton, J. Willis, 1207 E. 36th St.—18
 Haase, John Henry, 4218 Harford Rd.—14
 Hachtel, Frank W., 122 W. Lafayette Ave.—17
 Hagan, Robert C., 141 W. Lanvale St.—17
 Hahn, Richard D., 1823 Park Avenue—17
 Haines, John S., 77A—11 E. Chase St.—2
 Hall, Arthur T., Jr., 2 E. Read Street—2
 Hall, Elmer G., 1631 E. North Ave.—13
 Hall, William S., 215 Woodlawn Road—10
 Hamburger, Louis P., 1207 Eutaw Place—17
 Hamburger, Louis P., Jr., 1207 Eutaw Place—17
 Hammer, Howell I., 1929 Edmondson Ave.—23
 Hanchett, Richard B., Medical Arts Building—1
 Handelsman, Jacob Charles, 1112 N. Calvert Street—2
 Hankin, Samuel J., 2331 Eutaw Place—17
 Hanrahan, Edward M., Jr., 1201 N. Calvert St.—2
 Hardy, Janet B., Glenarm, Md.
 Harmon, Louis E., 2224 Madison Ave.—17
 Harper, Paul, 615 N. Wolfe St.—5
 Harris, Aaron, 2360 Eutaw Place—17
 Harris, Thomas W., 1824 W. Franklin Street—23
 Harrison, Edmund P. H., 2903 N. Charles St.—18
 Harrison, Harold E., 3001 Fordney Lane—7
 Hart, Jeremiah A., 311 W. 31st St.—11
 Hartman, Oscar, 1801 Eutaw Place—17

Hartman, William L., 3900 N. Charles Street—18
 Hartz, Alvin T., 3612 Eldorado Avenue—7
 Hartz, Jerome, 11 E. Chase St.—2
 Harvey, A. McGehee, Johns Hopkins Hospital—5
 Hawkins, John Frederick, Jr., 1308 Kitmore Road—12
 Haws, John March, 1101 N. Calvert St.—2
 Hayleck, Mary L., 4401 Underwood Road—18
 Hayward, Eugene H., 115 E. Eager St.—2
 Healy, Robert F., Medical Arts Bldg.—1
 Hebb, Donald B., Cockeysville, Md.
 Heghinian, Jeanette R., 2212 South Road—9
 Helfrich, Raymond F., 519 Lyndhurst St.—29
 Helfrich, William G., 5006 Roland Ave.—10
 Henning, Emil Heller, Jr., 601 Winans Way—29
 Hensen, Henry Mathias, 20 E. Preston St.—2
 Herman, N. B., 1041 St. Paul St.—2
 Hersperger, W. Grafton, 12 E. 33rd St.—18
 Hewitt, J. Frank, 922 W. University Pkwy.—10
 Hibbits, John Thomas, Medical Arts Bldg.—1
 Higgins, I. Bradshaw, 2243 Madison Ave.—17
 Highstein, Benjamin, 121 S. Highland Ave.—24
 Highstein, Gustav, 3503 Garrison Blvd.—15
 Hill, Lewis B., Sheppard-Enoch Pratt Hospital, Towson 4, Md.
 Hills, Ralph G., 18 E. Eager St.—2
 Himelfarb, Albert Joseph, 1801 Eutaw Place—17
 Hirshfeld, John H., 6919 Harford Rd.—14
 Hoffman, Gilbert Mahlon, 1724 Freedomway, North
 Hoffman, Reuben, 3602 Forest Park Avenue—16
 Hogan, J. F., 7 E. Preston St.—2
 Holden, Frederick A., Medical Arts Building—1
 Hollander, David H., 5514 Kemper Road—10
 Hollies, Henry Wirt Duvall, 3308 W. North Avenue—16

- Holly, Julius David, 7701 Seven Mile Lane—8
- Homer, Harry L., Riderwood, Md.
- Hood, Bowman J., 317 Broxton Rd.—12
- Hooper, Z. Vance, 3534 Ellerslie Ave.—18
- Hopkins, H. Hanford, 1201 N. Calvert St.—2
- Hopkins, John Vernon, 129 E. Redwood St.—2
- Horine, Cyrus F., Medical Arts Bldg.—1
- Howard, John Eager, Johns Hopkins—5
- Howard, John Tilden, 12 E. Eager St.—2
- Hull, Harry Clay, Medical Arts Bldg.—1
- Hulla, Jaroslav, 2214 E. Fayette St.—31
- *Hummel, Leonard M., 14 E. Read Street—2
- Hundley, J. Mason, Jr., Medical Arts Bldg.—1
- Hunner, Guy Le Roy, Medical Arts Bldg.—1
- Hurwitz, Abraham B., 3048 E. North Avenue—16
- Hurwitz, Chester E., 2218 Eutaw Place—17
- Hutchins, Amos F., 1227 N. Calvert St.—2
- Hutchins, Elliott H., 1227 N. Calvert St.—2
- Hyde, Harry C., 1100 E. North Ave.—1
- Hyman, Calvin, 2356 Eutaw Place—17
- Hyman, Nathan B., 2502 Rogers Avenue—15
- Illiff, Charles Edwin, 12 W. Read St.—1
- Ingalls, George Sam, 703 Cathedral St.—1
- Insley, J. Knox, Jr., 4312 Parkside Drive—6
- Isaacs, Benjamin H., 2600 E. Baltimore St.—24
- Jackson, Robert L., 600 N. Arlington Ave.—17
- Jacobs, Louis L., 1700 Eutaw Place—17
- Jacobson, Meyer William, 2310 Eutaw Place—17
- Jacobus, Wayne N., Church Home & Hospital—31
- Jahreiss, Walter O., 3703 Clarks Lane—15
- Jandorf, R. Donald, Lake Drive—17
- Janney, Francis W., 405 N. Charles St.—1
- Janney, Nathan, 7101 Harford Rd.—14
- Januszski, Francis J., 540 N. Linwood Avenue—5
- Jarrett, Edwin B., 11 E. Chase Street—2
- Jaworski, Melvin J., 2711 Eastern Avenue—24
- Jennings, F. Leslie, Medical Arts Bldg.—1
- Jeppi, Joseph, 828 Park Avenue—1
- Jerardi, Joseph V., 107 Armagh Drive—12
- Jewett, Hugh J., 1201 N. Calvert St.—2
- Johns, Thomas Nelson Page, Johns Hopkins Hospital—5
- Johnson, Edward S., 203 Chancery Rd.—18
- Johnson, Elliott W., 3432 Frederick Rd.—29
- Johnson, Herbert C., 601 N. Broadway—5
- Johnson, Marius P., Medical Arts Bldg.—1
- Johnson, Robert W., Jr., 4 E. Madison St.—2
- Johnson, Robert W., 1014 St. Paul Street—2
- Johnson, Whedon, 1300 Winston Road—12
- Johnson, William R., Medical Arts Bldg.—1
- Jones, Benjamin F., 5F Garden Apartments—10
- Jones, Everett D., 101 E. Biddle Street—2
- Jones, Georgeanna Seegar, Medical Arts Building—1
- Jones, H. Alvan, 1107 St. Paul St.—2
- Jones, Howard W., Jr., Medical Arts Building—1
- Josephs, David, U. S. Army Hospital, Ft. Campbell, Kentucky
- Joska, Vincent V., 3714 Loch Raven Boulevard—18
- Joslin, Blackburn Smith, 105 Woodlawn Road—10
- Joslin, C. Loring, 11 E. Chase Street—2
- Kac, Arthur, 2405 Garrison Blvd.—16
- Kadan, Ferd E., 1308 Ramblewood Rd.—6
- Kader, Benjamin, 2306 Eutaw Place—17
- Kallins, Edward S., 1847 W. North Avenue—17
- Kaltreider, D. Frank, 1526 Northwick Road—18
- Kammer, William H., Jr., 906 E. 37th Street—18
- Kane, Harry F., 913 E. Belvedere Avenue—12
- Kaplan, Isadore, 3314 Marnat Road—8
- Kappelman, Melvin D., 817 St. Paul St.—2
- Kardash, Theodore, Medical Arts Building—1
- Karlgin, Arthur, Northwood Apts.—18
- Karlgin, Walter E., 4331 Harford Rd.—14
- Karns, Clyde F., Medical Arts Bldg.—1
- Karns, James R., 700 Cathedral Street—1
- Kates, Harry Franklin, 517 Scott Street—30
- Katzenberger, James W., Medical Arts Bldg.—1
- Kayser, Fayne Albert, Medical Arts Bldg.—1
- Keller, Charles J., 222 W. Monument St.—1
- Kelly, Bernard V., National Marine Bank Bldg.—2
- Kelly, Edmund Brindon, 1418 Eutaw Place—17
- Kelly, Vernon C., 13 E. Eager Street—12
- Kelmenson, Harry, 1308 Eutaw Place—17
- Kemick, Irvin B., 5416 Reisterstown Road—16
- Kemler, J. I., 1908 Eutaw Place—17
- Kemp, Katherine Virdin, 20 E. Preston Street—2
- Keown, Lauriston L., 431 E. Lake Ave.—12
- Keown, Thomas William, 1938 Linden Ave.—17
- Kerman, Edward F., 3700 Liberty Heights Avenue—15
- Kern, Howard M., Esplanade Apartments—17
- Ketron, Lloyd W., 1125 St. Paul St.—2
- Ketzky, Joseph William, 11 E. Chase St.—2
- Keyser, R. L., Wentworth Apts.—1

- Kieffer, Richard F., 15 E. Fayette Street—2
 Kieffer, Richard F., Jr., 5220 Spring-lake Way—12
 Kiel, August, Jr., 1715 Northbourne Road—14
 Kilby, Walter L., Medical Arts Bldg.—1
 Kimberly, Robert C., 802 Cathedral St.—1
 Kimzey, F. J., 2700 Harford Ave.—18
 King, John Theodore, 1210 Eutaw Place—17
 King, Joseph D. B., 404 Hawthorn Road—10
 Kirby, Francis Joseph, 110 E. North Ave.—2
 Kirkpatrick, Crawford N., Jr., 6 E. Eager Street—2
 Kirsh, Milton B., 2320 Eutaw Place—17
 Kitlowski, Edward A., 3301 N. Charles Street—18
 Kleiman, Bernard S., 1113 N. Calvert Street—2
 Kleiman, Norman R., 3803 Edmondson Avenue—29
 Klemkowski, Irvin P., 11 E. Chase St.—2
 Klijanowicz, Stanley B., 3500 Erdman Avenue—13
 Klimes, Louis F., 2623 E. Monument St.—5
 Klinefelter, Harry F., Jr., 1101 St. Paul St.—2
 Kroman, E. H., 44 W. Biddle St.—1
 Klotz, Ben, 817 St. Paul St.—2
 Knapp, Hubert Clement, 3123 N. Calvert St.—18
 Knipp, George A., 3030 Edmondson Ave.—23
 Knipp, Harry Lester, 4116 Edmondson Avenue—29
 Knowles, F. Edwin, Jr., 513 N. Charles St.—1
 Knox, J. H. M., Jr., 211 Wendover Rd., Guilford—18
 Knox, James H. Mason, III, 2919 St. Paul St.—18
 Kochman, Leon A., 3508 Dennison Road—15
 Kohlerman, Nicholas John, 3106 Batavia Avenue—14
 Kohn, Walter, 102 E. Fort Ave.—30
 Kolman, Lester N., 3700 Park Heights Ave.—15
 Kolodner, Louis J., 1109 N. Calvert Street—2
 Konigsberg, Wilfred K., 1211 Eutaw Place—17
 Koontz, Amos R., 1014 St. Paul St.—2
 Kourey, Salem W., 4404 Bedford Place—18
 Krause, Louis A. M., 11 E. Chase Street—2
 Kremen, Abraham, 2355 Eutaw Place—17
 Krepp, Martin W., 4202 Kolb Ave.—6
 Kress, Milton B., Medical Arts Building—1
 Krieg, Edward L. J., 5019 Old Frederick Road—29
 Kroll, Louis J., 4101 Springdale Ave.—7
 Krulevitz, Keaciel K., 244 N. Hilton Street—29
 Krumrein, Louis Frederick, 722 N. Kenwood Ave.—5
 Kunkowski, Andrew, 2529 Eastern Ave.—24
 Kurland, Albert A., 817 St. Paul Street—2
 Kyper, Fred T., 421 Medical Arts Building—1
 Lachman, Harry, 2322 Callow Avenue—17
 Lally, Leo A., 3517 Edmondson Ave.—29
 Lambros, Byruth Lenson, 1224 Bloomingdale Rd.—16
 Lang, Milton Charles, 2117 Belair Rd.—13
 Langeluttig, Harry Vernon, 715 N. Charles Street—1
 Langworthy, Ortello R., 1503 Bolton Street—17
 Laroque, Herbert E., 1800 N. Charles St.—1
 Lasell, Eldridge L., Greenway Apartments, 34th & Charles Streets—18
 Laukaitis, Joseph, 679 Washington Blvd.—30
 Lavenstein, Arnold F., Temple Garden Apts.—17
 Lavy, Louis T., 1844 W. North Ave.—17
 Leach, C. Edward, 14 E. Eager St.—2
 Lebo, Lester, Medical Arts Bldg.—1
 Lederman, Edward I., 2515 Liberty Heights Avenue—15
 LeDoux, Clarence W., 3023 Eastern Avenue—24
 Legge, John E., 700 Cathedral Street—1
 Legge, Kenneth Dartmouth, Medical Arts Bldg.—1
 Legum, Samuel, 1261 E. North Ave.—2
 Leitz, Thomas Frederick, Temple Garden Apts.—17
 Lenhard, Raymond E., 1107 St. Paul St.—2
 Lerman, Philip H., 2038 E. Baltimore Street—31
 Lerner, Philip F., 1111 St. Paul Street—2
 Leslie, Franklin Earl, 623 Wilton Road, Towson 4
 Levi, J. Elliott, 1020 St. Paul Street—2
 Levickas, Herbert J., 5305 E. Drive—27
 Levin, H. Edmund, 3400 Hilton Rd.—15
 Levin, Milton, 2224 Eutaw Place—17
 Levin, Manuel, 4818 Reisterstown Rd.—15
 Levin, Morris Benjamin, 218 E. University Parkway—18
 Levine, Stuart Charles, 809 Cathedral Street—1
 Levy, Charles S., Medical Arts Bldg.—1
 Levy, Isadore I., 3530 Hilton St.—15
 Levy, Kurt, 3103 N. Charles Street—18
 Lewis, J. L., Jr., 5907 Wakehurst Way—12
 Lewison, Edward F., 1020 St. Paul Street—2
 Liberles, Lucille, 1739 Eutaw Place—17
 Liberto, Joseph R., 1011 N. Charles Street—1
 Lieberman, Alfred T., 29 E. Mt. Vernon Place—2
 Lillianthal, Joseph L., Jr., Johns Hopkins Hospital—5
 Lilienfeld, Samuel, 714 E. Preston St.—2
 Lillich, B. A., 3615 Falls Rd.—11
 Linas, Sydney, 2240 Eutaw Place—17
 Linden, Harry, 14 S. Broadway—31
 Li Pira, Joseph Francis, 2904 Arlington Avenue—14
 Lippy, George Dewey, 206 Kimble Road—18
 Lisansky, E. Theodore, 3210 Liberty Heights Ave.—15
 Little, Luther E., 10 W. Madison St.—1
 Livingston, Samuel, 1039 St. Paul Street—2
 Lloyd, Oliver S., 701 Cathedral St.—1
 Loch, Walter Edward Eric, 1039 N. Calvert Street—2
 Locher, R. W., 31 E. North Ave.—2
 Lockard, James Douglas, 802 Cathedral St.—1

- Loebl, Julius, 2303 Sulgrave Avenue—9
- Loewald, Hans W., 11 E. Chase St.—2
- Loker, F. Ford, 1120 St. Paul St.—2
- Long, John Herman, 11 E. Chase St.—2
- Long, Wilmer Newton, Jr., 11 E. Chase Street—2
- Longcope, Warfield T., Cornhill Farms, Lee, Mass.
- Looper, Edward A., 104 W. Madison St.—1
- Love, William S., Jr., 1214 N. Calvert Street—2
- Lovitt, William V., Jr., 3501 St. Paul Street, Apt. 423—18
- Lowenbach, Hans, Duke University Hospital, Box 3518, Durham, N. Carolina
- Lowitz, Irving Robert, 3815 Oakford Avenue—15
- Lowman, Milton E., 4843 Park Heights Avenue—15
- Lubin, Paul S., 320 Patapsco Ave.—25
- Luetscher, John Arthur, 12 E. Eager St.—2
- Lumpkin, Morgan LeRoy, 914 N. Charles St.—1
- Lumpkin, William R., 307 E. 33rd St.—18
- Lupo, Deonis M., 11 E. Chase St.—2
- Lynn, William Dawson, 1547 Northgate Road—18
- McAllister, William B., New Haven Hospital, New Haven, Connecticut
- McCarthy, Charlotte, 618 Medical Arts Bldg.—1
- McCarty, Harry D., 37 W. Preston St.—1
- McCauley, A. Franklin, 2843 St. Paul St.—18
- McClafferty, William J., 315 St. Duns-tans Road—12
- McConachie, Alexander Douglas, 805 N. Charles St.—1
- McCormack, Lloyd L., 11 E. Preston Street—2
- McCosh, James N., 312 Dixie Drive—4
- McDonald, George, 844 N. Carey Street—17
- McDonnell, Edmond J., 4 E. Madison Street—2
- McElwain, Howard B., 31 E. North Ave.—2
- McFadden, Robert B., 19 Wyndercrest Avenue—29
- McGoogan, Malcolm T., 1229 Eve-sham Avenue—12
- McGrath, Denis Joseph, 1 E. Randall Street—30
- McKenzie, W. Raymond, Medical Arts Bldg.—1
- McLanahan, Samuel, 108 E. 33rd St.—18
- MacLaughlin, D. C., 4508 Edmondson Village—28
- McLaughlin, Francis Joseph, 11 E. Chase Street—2
- McLaughlin, John H., 3700 Loch Raven Boulevard—18
- MacLean, Angus Lloyd, 1201 N. Calvert St.—2
- McLean, George, Medical Arts Bldg.—1
- McLean, Ross L., VA Hospital, Tupper Lake, New York.
- MacMinn, Charles C., Jr., 2911 E. Baltimore St.—24
- McNally, Hugh B., 1008 Winding Way—10
- Mace, Albert J., The Terraces, Mt. Washington—9
- Machen, John W., 6331 Bel Air Rd.—6
- Macht, Allan Harris, 4058 Edgewood Road—15
- Macht, David I., 3420 Auchentoroly Terrace—17
- Mackowiak, Stephen C., 6714 Holabird Ave.—22
- Macks, I. M., 3506 Liberty Heights Ave.—15
- Maginnis, Helen Irene, 719 Medical Arts Bldg.—1
- Magladerry, John William, Johns Hopkins Hospital—5
- Manchester, Thomas, 806 Cathedral Street—1
- Mandy, Arthur Jennings, Medical Arts Bldg.—1
- Mandy, Theodore E., Medical Arts Bldg.—1
- Manieri, Frank V., 3503 Crossland Avenue—13
- Mansdorfer, G. B., 2937 N. Charles St.—18
- Mansfield, William K., 44 W. Biddle St.—1
- Marburg, Rudolf, 11 E. Chase Street—2
- Marek, Charles B., 801 N. Luzerne Ave.—5
- Marino, Frank C., 1129 St. Paul St.—2
- Markley, Raymond Law, Hospital for the Women of Md.—17
- Markowitz, Milton, 8 E. Eager Street—2
- Marr, Ernest G., 516 Cathedral St.—1
- Marr, William G., Latrobe Apartments—2
- Marriott, Henry J. L., 203 W. Lanvale Street—17
- Marston, James G., 516 Cathedral St.—1
- Martin, Clarence W., 1078 Cameron Road—10
- Martin, Lay, 1201 N. Calvert St.—2
- Marvel, N. Clyde, Maryland Casualty Co.—3
- Maser, Louis Robert, 4335 Park Heights Avenue—15
- Maseritz, I. H., Temple Garden Apartments, Cloverdale Road & Madison Avenue—17
- Mason, Robert E., 9 E. Chase St.—2
- Massenburg, George Yellott, 250 Rodgers Forge Road—4
- Matchar, Joseph Charles, 3623 Liberty Heights Ave.—15
- Maxson, Charles Walter, 2 W. Read St.—1
- May, Robert E., 1200 Woodbourne Avenue—12
- May, William T., 2034 Eutaw Place—17
- Mayer, Erwin E., The Esplanade—17
- Mays, Howard Brooks, 715 N. Charles Street—1
- Mech, Karl F., 11 E. Chase Street—2
- Menning, Joseph H., 101 W. Read St.—1
- Meranski, Israel P., 3354 Dolfield Ave.—15
- Merkel, Walter C., Union Memorial Hospital—18
- Meyer, Eugene, III, 208 Northway—18
- Michel, William, 1015 Poplar Grove St.—16
- Michelson, Elliott, 1801 Eutaw Place—17
- Michelson, R. A., 2230 Eutaw Place—17
- Milan, Albert Richard, 320 E. 33rd St.—18
- Milan, Edward F., 682 Washington Blvd.—30
- Millea, William Lawrence, 3101 St. Paul Street—18
- Miller, Benjamin, 2030 Wilkins Ave.—23
- Miller, Harry A., 2452 Eutaw Place—17
- Miller, Isaac, 1228 S. Charles St.—30
- Miller, Jacob M., 1613 E. Baltimore St.—3

- Miller, James Patton, 804 Cathedral Street—1
- Miller, John Ernest, 231-A Burke Avenue, Towson 4
- Miller, Joseph G., 107 W. Saratoga St.—1
- Miller, Lowell Stephen, Johns Hopkins Hospital—5
- Miller, Meyer, 4832 Park Heights Ave.—15
- Miller, Mitchell H., 311 Broxton Road—12
- Miller, Stanley, 914 N. Charles Street—1
- Mintzer, Donald W., 1922 E. Belvedere Avenue—14
- Mirick, George S., Johns Hopkins Hospital—5
- Mitchell, George W., 11 E. Chase St.—2
- Mitchell, Robert Bruce, Jr., 704 Cathedral St.—1
- Mitchener, James Samuel, Jr., Church Home & Hospital—31
- Mohr, Charles F., Medical Arts Bldg.—1
- Mohr, Dwight H., 301 S. Ellwood Ave.—24
- Molofsky, Leonard Carl, 1109 N. Calvert Street—2
- Moncure, Turner A., 100 St. Paul St.—2
- Monninger, Arthur C., 800 E. North Ave.—2
- Moore, Alfred C., 2122 Broening Highway—3
- Moore, James I., 11 E. Chase St.—2
- Moore, Joseph Earle, Medical Arts Bldg.—1
- Moore, Kirk, The Latrobe—2
- Moore, Marcus W., Sr., 1655 W. North Avenue—17
- Moore, J. Duer, 3105 Bel Air Rd.—13
- Morgan, Russell H., Johns Hopkins Hospital—5
- Morgan, Zachariah R., 10 E. Eager St.—2
- Morris, Frank Kailer, 3913 Juniper Road—18
- Morris, John David, 14 E. Eager St.—2
- Morrison, John Huff, 6 E. Read St.—2
- Morrison, Samuel, 11 E. Chase St.—2
- Morrison, T. H., 11 E. Chase St.—2
- Morrow, Andrew G., Johns Hopkins Hospital—5
- Mortimer, Egbert Laird, Jr., 207 Paddington Rd.—12
- Moses, Benjamin B., 448 N. Luzerne Ave.—24
- Moses, Bessie L., 519 Medical Arts Bldg.—1
- Mostwill, Ralph, 1805 Eutaw Place—17
- Muller, S. Edwin, 2 W. Read St.—1
- Mulligan, E. James, 5600 Harford Rd.—14
- Muncie, Wendell S., 11 E. Chase St.—2
- Murgatroyd, George W., Jr., 1114 St. Paul St.—2
- Murray, John Gardner, Jr., 9 E. Chase St.—2
- Muse, Joseph E., Jr., 5 West 29th St.—18
- Muse, William T., 5 W. 29th Street—18
- Myerowitz, Joseph Robert, 5145 Park Heights Ave.—15
- Myers, John A., 104 E. Biddle St.—2
- Myers, Joseph Carl, 1401 E. Cold Spring Lane—18
- Myers, Philip, 2425 Eutaw Place—17
- Nachlas, I. William, 1109 N. Calvert St.—2
- Nachlas, N. Edward, Rochester Court Apartments, Brooks Lane—17
- Nance, Fuller, 522 Rossiter Avenue—12
- Naquin, Howard A., Johns Hopkins Hospital—5
- Needle, Nathan E., 2314 W. North Ave.—16
- Neill, William, Jr., 1418 Eutaw Place—17
- Nelson, Alfred Turner, 4526 Marble Hall Rd.—12
- Nelson, James Wharton, Earl Court Apts., Preston & St. Paul Sts.—2
- Nelson, Russell A., Johns Hopkins Hospital—5
- Nesbitt, John A., Jr., 20 E. Preston Street—2
- Neubauer, Imre, 936 Patapsco Ave.—25
- Newell, Edward Alphonso, 46 Gardner Street, Boston 34, Massachusetts
- Newman, Elliott V., Johns Hopkins Hospital Physiological Section, North Broadway—5
- Ney, Grover C., 2401 Linden Ave.—17
- Niblett, Walter S., 2220 Garrison Ave.—16
- Nichols, Firmadge K., 4711 Roland Avenue—10
- Nitsch, Norbert C., 2151 Wilkins Ave.—23
- Norton, John Charles, Jr., 1933 W. Baltimore Street—23
- Norwood, V. Hyatt, Church Home & Inf.—31
- Novak, Edmund Rogers, 26 E. Preston Street—2
- Novak, Eduard, Medical Arts Bldg.—1
- Novak, Emil, 26 E. Preston St.—2
- Nowak, Sigmund R., 408 S. Patterson Park Avenue—31
- Nussbaum, Kurt, 2804 Waldorf Avenue—15
- O'Connor, John A., 11 E. Chase St.—2
- O'Donovan, Charles, Jr., 3111 N. Charles Street—18
- Ogden, Frank N., 2701 N. Calvert St.—18
- O'Hare, James Stewart, 3100 St. Paul Street—18
- O'Neill, Allen J., 1119 Gleneagle Road—12
- O'Rourke, Thomas R., 104 W. Madison St.—1
- Osborne, John C., 3122 Northern Parkway—14
- Otenasek, Frank J., 6 E. Eager St.—2
- Owen, Arthur John, 1200 E. Belvedere Ave.—13
- Owen, John Keller, 104 W. Madison St.—1
- Owens, Ella Uhler, 10 E. Chase Street—2
- Owens, William C., Johns Hopkins Hospital—5
- Owings, James C., 18 W. Franklin St.—1
- Ozazewski, John Casimir, 1540 Oakridge Road—18
- Padget, Paul, Veterans Administration Hospital, Fort Howard
- Pair, James Mansfield, 400 N. Carrollton Avenue—23
- Palese, John Mitchell, 11 E. Chase Street—2
- Park, Edwards A., Pathological Building, Johns Hopkins Hospital—5
- Park, William F., 3719 Woodbine Avenue—7
- Parker, Robert T., 620 Wilton Road—Towson 4
- Parrott, Frank Strong, Baltimore City Hospitals—24
- Parsons, John Warner, 11 E. Chase St.—2

Pass, I. Earl, 4001 Wilkins Ave.—29
 Patt, Howard H., 3923 Wabash Avenue—15
 Patton, Genieann Parker, 1726 Pin Oak Road, Towson 4
 Patz, Arnall, 920 St. Paul Street—2
 Paulson, Moses, 11 E. Chase St.—2
 Peake, Clarence William, 4508 Harford Rd.—14
 Pearce, William F., 2105 N. Charles St.—18
 Pearce, Wm. H., 2105 N. Charles St.—18
 Peck, John Lyman, 5506 Lombardy Place—10
 Peirce, E. Converse, 2nd, 4512 Marble Hall Road—12
 Pembroke, Richard H., Jr., 1311 N. Calvert Street—2
 Pendleton, George H., 1723 Druid Hill Avenue—17
 Pessagno, Daniel J., Medical Arts Bldg.—1
 Peters, H. Raymond, 1127 N. Calvert St.—2
 Phelan, Patrick C., Jr., 239 Linden Ave., Towson—4
 Phelps, Winthrop Morgan, 3038 St. Paul St.—18
 Phillips, David Lee, 6104 Frederick Road—18
 Phillips, Eugenie E., 1612 Edmondson Avenue—23
 Phillips, Otto C., 2708 Alden Road
 Pierce, Leslie Harrall, Johns Hopkins Hospital—5
 Pierpont, Ross Z., 111 W. Monument St.—1
 Pierson, J. W., 1107 St. Paul St.—2
 Pincoffs, Maurice C., University Hospital—1
 Pines, Samuel R., The Latrobe Apartments—2
 Pleasants, Jacob Hall, 201 Longwood Rd., Roland Park—10
 Polek, Melvin F., 4200 Sheldon Avenue—6
 Polvogt, Leroy M., 1201 N. Calvert St.—2
 Porter, Harry P., 6473 Blenheim Road—12
 Pound, John C., 515 Drury Lane—29
 Prager, Helmut, 1308 Eutaw Place—17
 Pratt, Louis J., 1633 Waverly Way—12
 Primakoff, H. William, Emersonian Apartments—17

Proctor, Donald F., Johns Hopkins Hospital—5
 Proctor, Samuel Edward, 104 W. Madison St.—1
 Pugh, Albert Ellsworth, Veterans Administration, Fort Howard, Md.
 Putterman, Morris N., 2324 Reisterstown Rd.—17
 Queen, J. Emmett, 4418 Norwood Road—18
 Racusin, Nathan, 206 S. Gilmore St.—23
 Radman, H. Melvin, Esplanade Apts., Eutaw Place & Brooks Lane—17
 Raffel, William, 803 Cathedral St.—1
 Ramsey, James H., 5711 Mineral Avenue, Halethorpe, Md.
 Ramundo, Michael R., 89 Avondale Ave., Clifton, N. J.
 Randolph, M. Elliott, 1101 St. Paul St.—2
 Rangle, Raymond V., 642 Washington Boulevard—30
 Raskin, Moses, 817 St. Paul St.—2
 Rathbun, Howard K., Carroll Manor Road, Baldwin, Md.
 Ratliff, Cliff, Jr., 4605 Edmondson Avenue—29
 Ravitch, Mark M., Johns Hopkins Hospital—5
 Rector, Robert C., 4581 Freedomway, West—13
 Reese, Fred M., 330 N. Charles St.—1
 Reifschneider, Charles A., 104 W. Madison St.—1
 Reifschneider, Herbert E., 104 W. Madison St.—1
 Reiter, Robert A., 3408 Windsor Ave.—16
 Renner, William F., 11 West 29th Street—18
 Revell, Samuel T. R., Jr., 11 East Chase St.—2
 Rich, Arnold L., Johns Hopkins Hospital—5
 Rich, Benjamin S., Medical Arts Bldg.—1
 Richards, Esther Loring, 41 W. Preston St.—1
 Richardson, Edward H., 9 E. Chase St.—2
 Richardson, Edward H., Jr., 9 E. Chase St.—2
 Richardson, Horace K., 11 E. Chase St.—2
 Richter, Christian F., 11 W. Biddle Street—1
 Richter, Conrad Louis, 2237 Lake Ave.—13

Ridgely, Irwin O., 201 W. Madison St.—1
 Rienhoff, William Francis, Jr., 1201 N. Calvert St.—2
 Ries, A. Ferdinand, 302 Northway, Guilford—18
 Riley, Eugene John, 2128 N. Calvert Street—18
 Riley, Richard Lord, 1901 Dixon Road—9
 Rinehart, Arthur M., 4823 Keswick Road—10
 Rinn, William Alexander, 40 Maple Drive—28
 Rizika, Stuart D., 3411 Rosedale Road—15
 Roach, Thomas Edward, 3629 Edmondson Ave.—29
 Robbins, Martin A., 1801 Eutaw Place—17
 Roberts, Davis P., 901 Cathedral Street—1
 Roberts, James A., 5800 Oakview Avenue—14
 Robertson, J. Clagett, 24 S. Broadway—31
 Robinson, Aaron, 1817 Eutaw Place—17
 Robinson, Daniel R., 2835 Gwynns Falls Pkwy.—16
 Robinson, G. Canby, 4712 Keswick Rd.—10
 Robinson, Harry M., 106 E. Chase St.—2
 Robinson, Harry M., Jr., 1024 N. Calvert Street—2
 Robinson, Raymond C. V., 1550 Pentwood Road—12
 Robnett, Dudley Anderson, 1643 Kingsway Road—18
 Rochberg, Samuel, 3906 Calloway Avenue—15
 Rodgers, William A., 152 Edgewater Apartments—21
 Roetling, Carl P., 1326 W. Lombard St.—31
 Rogers, Harry L., 101 E. Preston St.—2
 Rohrer, Caleb W. G., 2814 Ailsa Ave.—14
 Roman, Paul, 1810 Eutaw Place—17
 Rosen, Harold, 1101 N. Calvert Street—2
 Rosen, Israel, 2413 E. Monument St.—5
 Rosenfeld, Morris, 3103 Bonnie Road—8
 Rosenthal, Gilbert White, 1739 Eutaw Place—17

Rosenthal, Harry William, 1902 Greenmount Ave.—18
 Ross, David, 4212 Patterson Park Avenue—15
 Rossberg, Clyde Arthur, 2411 Washington Boulevard—30
 Rothholz, Alma S., Apt. 1-C, 822 Belgian Avenue—18
 Rowland, James M. H., 1118 St. Paul St.—2
 Rowland, William M., 1118 St. Paul St.—2
 Rubin, Samuel, 1109 N. Calvert Street—2
 Rubin, Samuel, 203 Patapsco Avenue—25
 Rubin, Seymour W., 2703 W. Belvedere Avenue—15
 Rubinstein, Hyman S., 2349 Eutaw Place—17
 Rudman, Gilbert E., 2517 W. Baltimore St.—23
 Rudo, Alvin D., Latrobe Apartments—2
 Russell, Thomas Edgie, 3901 N. Charles Street—18
 Russo, James, 819 Kingston Road—12
 Rutledge, Benj. Huger, 18 E. Eager St.—2
 Ruzicka, F. Fred, 800 N. Patterson Park Ave.—5
 Rysanek, William J., 801 N. Kenwood Ave.—5
 Rysanek, William J., Jr., 1013 N. Calvert St.—2
 Rytina, Anton George, 5003 St. Albans Way—12
 Sachs, Louis, Marlborough Apts.—17
 Sacks, Milton S., University Hospital—1
 Salik, Julian V., 3602 Clarin Road—15
 Sanderson, John W., 1714 N. Caroline St.—13
 Sardo, Robert S., 303 Woodbourne Avenue—12
 Sarubin, Benjamin, 2128 W. North Ave.—17
 Sauber, Irvin, 3003 Garrison Boulevard—16
 Saunders, LeRoy W., 216 Goodale Rd.—12
 Savage, John Edward, 231 Hopkins Road—12
 Sawyer, George J., Jr., 4808 Harford Rd.—14
 Sawyer, William H., Jr., 4928 West Hills Road—29

Saylor, Lloyd E., 3902 Greenmount Ave.—18
 Sborofsky, Isadore, 4212 Oakford Ave.—15
 Scagnetti, Albert, 1729 W. Lombard St.—23
 Scarborough, Clarence P., Jr., 104 W. Madison St.—1
 Schaefer, John F., 401 Random Road—18
 Schaefer, Otto, 920 St. Paul St.—2
 Schaefer, Theodore A., 3610 Harford Rd.—18
 Schaffer, Alexander J., 1109 St. Paul—2
 Schapiro, Abraham, 2028 Eutaw Place—17
 Schapiro, William B., 2415 Eutaw Place—17
 Schenker, Paul, 2424 Eutaw Place—17
 Scher, Ernest, 1701 Eutaw Place—17
 Scher, Isadore, 1115 N. Calvert St.—2
 Scherlis, Leonard, 1214 N. Calvert Street—2
 Scherlis, Sidney, 1214 N. Calvert St.—2
 Scheurich, John A., 1337 S. Charles St.—30
 Scheye, Henry W., 3921 Edmondson Ave.—29
 Schiff, Hyman, 3429 Liberty Heights Avenue—15
 Schimek, Robert A., Johns Hopkins Hospital—5
 Schimunek, Emanuel, 842 S. East Ave.—24
 Schlesinger, George Gerard, 20 E. Preston Street—2
 Schmidt, Jacob Edward, 2924 Brighton St.—16
 Schmitz, William J., 118 Midhurst Rd.—12
 Schnitzer, Eugene, 3904 S. Hanover Street—25
 Schochat, Albert J., 2302 Edmondson Ave.—23
 Schochet, George, 1218 N. Calvert St.—2
 Schoenrich, Herbert, Calvert & Preston Sts.—2
 Scholz, Roy O., 11 E. Chase St.—2
 Schonfeld, Paul, 2301 Annapolis Rd.—30
 Schreiber, M. B., 3506 Ellamont Rd.—15
 Schuman, William, 1716 Eutaw Place—17

Schwartz, Daniel J., 2320 Eutaw Place—17
 Schwartz, Theodore A., 834 Park Ave.—1
 Schwentker, Francis F., 209 Tunbridge Road—10
 Scott, Eleanor, 1014 St. Paul St.—2
 Scott, Henry William, Jr., 207 Longwood Road—10
 Scott, John M., 8 Longwood Road—10
 Scott, William Wallace, Rider Hill Rd., Ruxton
 Seegar, J. King B. E., Jr., 3714 Winterbourne Road—16
 Seidel, Henry Murray, 3119 Bancroft Road—15
 Seidel, Herman, 2404 Eutaw Place—17
 Seliger, Robert V., 2030 Park Ave.—17
 Serra, Lawrence M., 11 E. Chase Street—2
 Settle, William Booth, 126 Homeland Ave.—12
 Shackelford, Richard T., 18 E. Eager St.—2
 Shamer, Maurice E., 3300 W. North Ave.—16
 Shanahan, Daniel S., 1945 W. Baltimore St.—23
 Shannon, George E., 100 St. Johns Road—10
 Shapiro, Albert, 1109 N. Calvert Street—2
 Sharfatz, George, 5106 Park Heights Ave.—15
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